2. RESOURCES FOR HEALTH

2.1. BUDGET AND EXPENDITURE

Total expenditure on health and health related activities are covering capital, recurrent and technical assistance. The 1996/97 budget estimate for the MOHCW is Z$ 1 810 157 000. This is a 5.46 % of the National estimated budget. The budget is distributed as presented in Table 10. Figure 17 illustrates the percentages of the budget per sub heads with the highest percentage of 86.86 % for medical health care as of FY 1996/97.

TABLE 10 : THE 1996/97 BUDGET FOR MOHCW

Sub-Heads of MOHCW	Z$ million
Administration and general	43.2
Medical Care Services	1 572.4
Preventive Services	186.7
Research	7.9

Source : MOHCW, Budget Estimates for the year ending June 1997, Finance Department

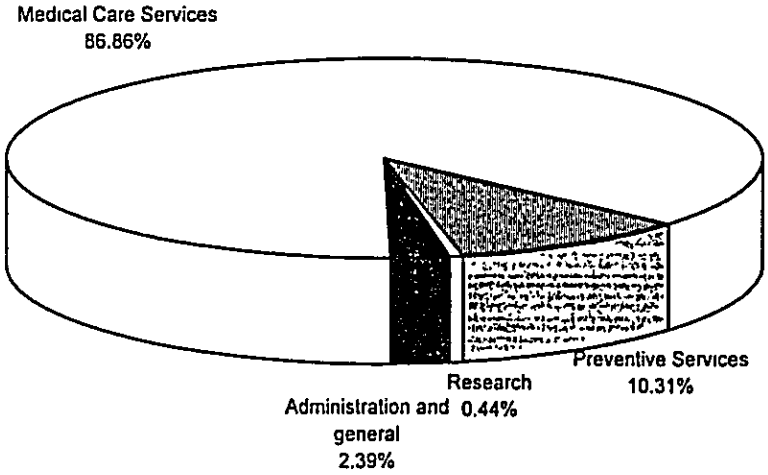

FIGURE 17 : PERCENTAGE OF TOTAL BUDGET SPENT PER SUB-HEAD 1996-97

The MOHCW budget is largely for recurrent items although it includes some spending on equipment and grants to missions which represent a small capital component. The budget does not include the donor funding. The Public Sector Investment Programme (PSIP) is allocating a budget for the construction work on health facilities by the Ministry of Public Construction and National Housing. An

additional capital fund is allocated through the Ministry of Local Government to the Municipalities. There is also substantial spending across a number of Ministries on rural water supplies and sanitation which can also be regarded as part of the Government's public health expenditure.

Table 11 presents the main sources of the health sector financing being the Government for about 70% for FY 94/95 with the MOHCW (30%) and other government departments, Local Government (municipalities, RDC), donors and voluntary organisations, missions, employers, individuals (through private health insurance). The donor community increased its funding to the health sector substantially from 1991 to 1995 as noticed in Table 11 and Figure 19. The Government funding increased over the years but the percentage in the overall funding decreased with 7%. Figure 18 illustrates the percentages of health funding by the main sources. It can be noticed that the Government is still the main source of funding the health sector, although their funding percentage is decreasing.

TABLE 11 : FUNDING OF THE HEALTH SECTOR BY YEAR - 1990-95

Year	Government	%	Local Authority	%	Missions	%	Donors	%	TOTAL
1990/91	527 586 000	79.8%	52 775 000	8.0%	44 333 000	6.7%	35 889 000	5.5%	660 583 000
1991/92	585 906 000	77.5%	55 034 500	7.3%	50 965 000	6.7%	64 302 000	8.5%	756 208 000
1992/93	722 780 000	75.2%	59 258 700	6.2%	74 191 300	7.7%	104 637 000	10.9%	960 867 000
1993/94	923 208 000	73.5%	69 504 000	5.5%	86 236 000	6.9%	176 613 000	14.1%	1 255 561 000
1994/95	1 160 109 000	72.4%	104 956 000	6.5%	121 600 000	7.6%	215 566 995	13.5%	1 602 231 995

Source : MOHCW, EDC-NHIS UNIT, 1996

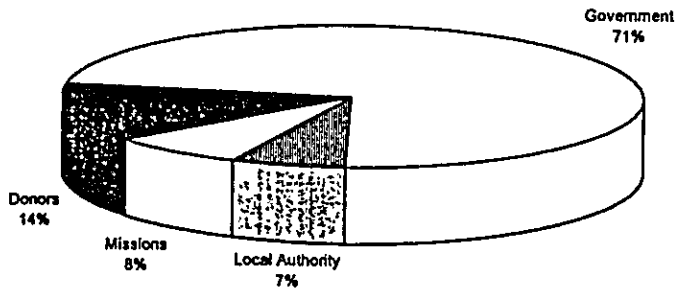

FIGURE 18 : PERCENTAGE OF FUNDING IN THE HEALTH SECTOR

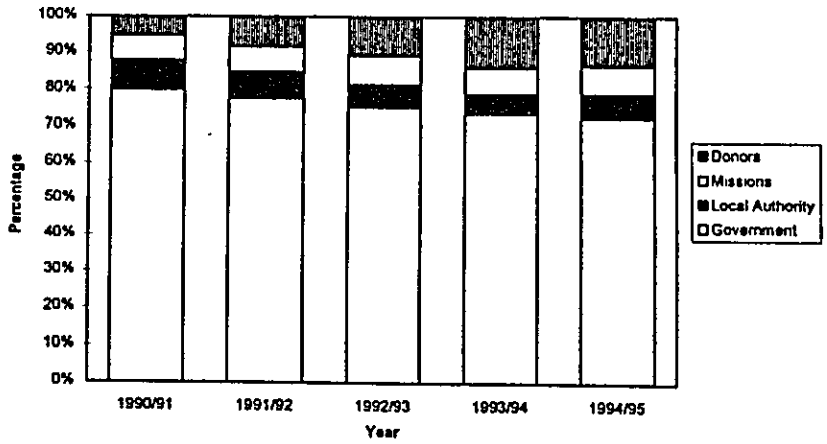

FIGURE 19 : PERCENTAGES OF FUNDING OF THE HEALTH SECTOR 1990-95

TABLE 12 : PROPORTION OF GROSS NATIONAL PRODUCT SPENT ON HEALTH AND THE RECURRENT HEALTH EXPENDITURE SPENT AS A PERCENTAGE OF THE TOTAL GOVERNMENT EXPENDITURE FROM FINANCIAL YEAR 1985-96

Year	GNP constant 1990 prices (Z$ million)	Total GOZ Expenditure (Z$)	Total Allocated to Health in Z$	Total Spent by Health Z$	% GNP spent on Health	% of Total GOZ Expend. Spent on Health
1985/86	8447	3 678 430 053	196 233 000	194 958 536	4.86	5.30
1986/87	9125	4 682 564 671	240 603 000	239 347 937	5.87	5.11
1987/88	11491	5 208 227 137	293 570 000	287 307 621	6.03	5.52
1988/89	14468	6 148 005 025	328 983 000	328 918 605	6.19	5.35
1989/90	17696	7 173 379 252	408,404,000	421 411 137	8.98	5.87
1990/91	24390	9 068 892 116	527 586 000	564 489 683	2.31	6.22
1991/92	27262	12 693 672 790	585 906 000	582 534 234	2.14	4.59
1992/93	32722	15 163 280 000	722 780 000	717 617 079	2.19	4.73
1993/94	40715	18 086 469 000	923 208 000	914 419 603	2.25	5.06
1994/95		25 668 005 000	1 160 109 000	1 154 750 927		4.50
1995/96		33 438 482 000	1 564 921 000			4.68
1996/97		33 153 058 610	1 810 157 000			5.46

Source : MOHCW, Finance Department, Annual Reports of the Comptroller & Auditor General 1987-1992, Quarterly Digest Statistics (CSO)

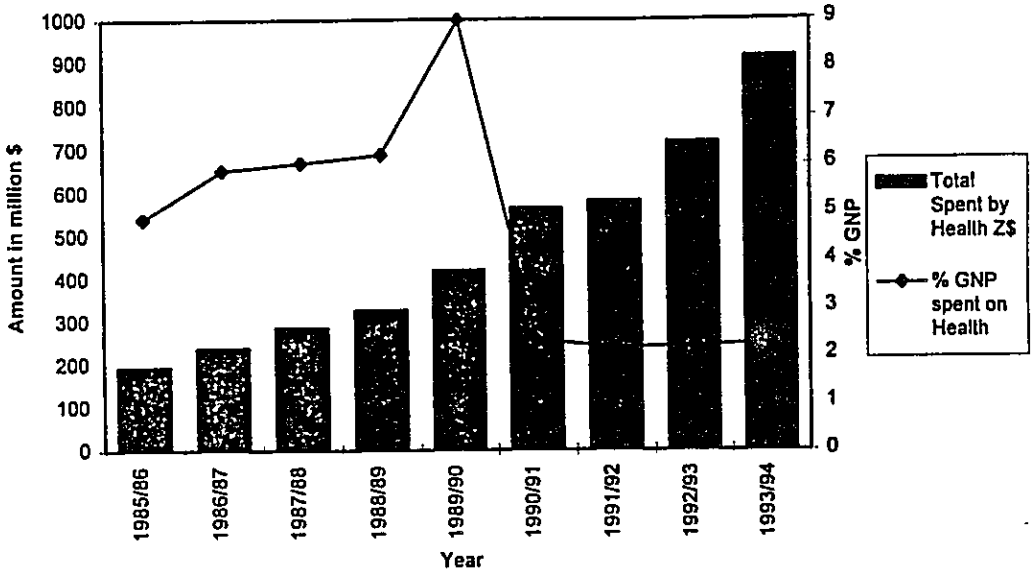

FIGURE 20 : TOTAL AMOUNT SPENT IN MILLION DOLLAR COMPARED TO PERCENTAGE OF GNP SPENT ON HEALTH 1985-94

Table 12 presents the percentage of GNP spent on health. Although the MOHCW 'estimate-budget' has grown in nominal terms from 1986 onwards, the percentage of the GNP spent on health decreased under ESAP from 1991 onwards caused by the high rates of inflation (average of 25%) during that period and the 3.1 percent average population growth rates. Figure 20 illustrates the decrease in percentage of GNP allocation to health while a consistent increase in health spending over the years is noticed. This decline in MOHCW share of Government resources is mostly due to the increase in the share of the Government budget allocated to debt relief over the past years. Debt relief was 22 % of the Government expenditure in FY 90 which grew to 30 % in FY 94. The MOHCW experienced this decrease since the beginning of ESAP because of the financial restructuring. This trend indicates that other financial resources need to be tapped to sustain the health spending for health services delivery or that the health spending need more rationalisation.

The MOHCW budgets for 1993/94, 1994/95, 1995/96, 1996/97 and the indicative estimates for 1997/98 and 1998/99 fiscal years are represented in Table 13 and Table 14 with the sub-division or sub-votes of the allocation for the main components as medical care services, preventive services, administration and research. The administration section or sub-vote 1, covers the Ministry Headquarters requirements. The medical care services line or sub-vote 2, of 1 572 million in FY 1996/97 covers all funding of health care facilities both for direct funding of government hospitals and clinics and grant funding to missions and councils. The preventive services line or sub-vote 3, of 186 671 000 in FY 1996/97 covers the salaries and other employment costs of the provincial medical directorate together with the operational costs of promotive and preventive health services such as disease control, health promotion, nutrition and other programmes. The sub-

section Research or sub-vote 4 caters for the operations of the Blair Research Institute. At the Ministry the sub-votes 2 and 3 are allocated to provinces on the basis of agreed formulae. Sub-vote 2 allocations are split between the Government institutions and the grants to local authorities and missions. The formulae to split the allocation depends on the parameters such as number of hospital beds, staff establishment, level of speciality and number of health institutions including the distance to the nearest referral centre. Sometimes there are supplementary allocations within a year changing the total budget allocation and the recurrent expenditure. The trend as presented in the overview of the allocation to the different sub-votes from 1982 to 1997 reveals that the fall in expenditure for preventive services budget was larger than for the curative services over the years as indicated in Table 15 and Table 16. The decline in the budget created a brain drain in the public sector and consequently affected adversely the health services delivery. A further breakdown shows that the highest percentage of the budget goes to salaries and allowances with a 34.94 % for FY 1996/97. The bill for medical and surgical supplies is continuously rising with a 28.03 % for the FY 1996/97 while the field operations of the preventive services take only a 3.99 % of the budget.

The total health sector expenditure is the spending on health care goods and services of the public and private sector together. There is however a lack of data to accurately estimate the total health sector expenditure especially for the private sector. The private sector health care expenditures are the sum of the direct payments for health care goods and services by individuals, expenditures for pharmaceuticals, health care benefits paid by health insurance for claims, benefits provided by community based risk pools and employer based health insurance plans, own source health care spending by missions, non-governmental organisations.

TABLE 13 : MOHCW BUDGET ESTIMATES PER SUB COMPONENTS 1993-96

Sub Categories	Budget Estimate in $ 1993-94	Budget Estimate in $ 1994/95	Budget Estimate in $ 1995-96	Un-audited Actual in $ 1995-96
I. Administration & General :				
A. Salaries , wages, and allowances	12 770 000	16 920 000	20 411 000	21 386 073
B. Subsistence and transport	2 300 000	2 500 000	2 800 000	2 305 076
C. Incidental expenses	5 780 000	6 000 000	8 750 000	6 781 638
D. Grants	140 000	150 000	175 000	145 000
E. Furniture & Equipment	180 00 0	150 000	150 000	41 388
II. Medical Care Services :				
A. Salaries, wages and allowances	303 400 000	360 200 000	484 143 000	484 120 483
B. Subsistence and transport	13 000 000	14 000 000	38 000 000	30 846 066
C. Incidental expenses	2 800 000	3 500 000	7 000 000	5 731 443
D. Supplies and services	201 400 000	240 100 000	360 760 000	367 512 541
E. Grants to local auth., miss. & volun. org.	144 800 000	158 300 000	289 800 000	286 446581
F. Other grants	95 500 000	97 000 000	135 000 000	135 000 000
G. Payments for govn. responsibility patient	120 000	150 000	200 000	68 601
H. Payments to non-govern. Institutions	8 500 000	10 000 000	10 000 000	7 996 245
J. Furniture and equipment	13 500 000	22 309 000	30 140 000	26 189 463
K. Capital : Equipment			2 050 000	2 206 111

Sub Categories	Budget Estimate in $ 1993-94	Budget Estimate in $ 1994/95	Budget Estimate in $ 1995-96	Un-audited Actual in $ 1995-96
III. Preventive Services :				
A. Salaries, wages and allowances	40 550 000	54 900 000	60 383 000	59 499 625
B. Subsistence and transport			24 500 000	26 533 094
C. Field Operations			60 500 000	54 021 956
D. Grants			23 020 000	21 066 667
E. Furniture and equipment			1 250 000	1 196 007
IV. Research :				
A. Salaries, wages and allowances	2 780 000	3 795 000	4 089 000	4 815 362
B. Subsistence and transport	525 000	600 000	700 000	536 99 6
C. Incidental expenses	1 000 000	1 000 000	1 000 000	976 886
D. Furniture and equipment	600 000	600 000	100 000	58 538
TOTAL BUDGET	923 208 000	1 066 839 000	1 564 921 000	1 545 48 1 838

Source :

Note : In FY 1993/94 and 1994/95 the amounts for certain activities are not recorded so that the totals of the budget estimates are different as recorded in Table 15.

TABLE 14 : MOHCW BUDGET ESTIMATES PER SUB COMPONENTS 1996-99

Sub Categories	Budget Estimate in $	Indicative Estimates	
	1996-97	1997-98	1998-99
I. Administration & General: $ 43 184 000			
A. Salaries, wages & allowances	**24 705 000**	28 134 000	31 814 000
B. Subsistence and transport	**4 000 000**	4 249 000	4 388 000
C. Incidental expenses	**13 625 000**	15 575 000	16 192 000
D. Grants	**680 000**	680 000	680 000
E. Furniture & Equipment	**174 000**	200 000	206 000
II. Medical Care Services: $ 1 572 412 000			
A. Salaries, wages & allowances	**532 745 000**	574 974 000	672 839 000
B. Subsistence and transport	**30 496 000**	31 204 000	32 159 000
C. Incidental expenses	**17 092 000**	19 626 000	21 589 000
D. Supplies and services	**507 335 000**	569 078 000	742 486 000
E. Grants to local authorities, missions & voluntary organis.	**291 300 000**	264 550 000	289 300 000
F. Other grants	**140 000 000**	130 000 000	135 000 000
G. Payments for government responsibility patient	**231 000**	265 000	274 000
H. Payments to non-governmental institutions	**8 000 000**	9 186 000	10 487 000
J. Furniture and equipment	**37 213 000**	40 010 000	41 318 000
K. Capital : Equipment	**8 000 000**	10 000 000	12 000 000
III. Preventive Services: $ 186 671 000			
A. Salaries, wages & allowances	**69 307 000**	79 271 000	85 401 000
B. Subsistence and transport	**20 762 000**	19 247 000	19 877 000
C. Field Operations	**72 137 000**	82 833 000	91 116 000
D. Grants	**23 020 000**	24 020 000	25 020 000
E. Furniture and equipment	**1 445 000**	1 659 000	1 714 000
IV. Research: $ 7 890 000			
A. Salaries, wages & allowances	**5 759 000**	6 697 000	7 424 000
B. Subsistence and transport	**809 000**	929 000	959 000
C. Incidental expenses	**1 206 000**	1 385 000	1430 000
D. Furniture and equipment	**116 000**	133 000	138 000
TOTAL BUDGET	**1 810 157 000**	1 913 905 000	2 243 811000

Source : MOHCW, Finance Department, Budget Estimates 1997

Table 15 of the trends reveals that although the allocation to the sub-sections is increasing in amounts, the MOHCW funding are much bigger for the Medical Care Services Section which represent mostly the personal health care. As these services are mostly for private benefit, they should be financed through private means. These should include fees for service and/or health insurance unless equity considerations are justified for government provision to those unable to pay. This could lower the percentage for medical care services and could be spent on preventive care services.

Table 16 illustrates the percentages of the sub-sections of the MOHCW resource allocation over the period 1990/91 until 1996/97. The Medical Care Services actually increased from approximately 75 percent of the MOHCW spending in the fiscal year 1990/91 to 85 % in FY 1994/95 and to 87 % in the fiscal year 1996/97. The preventive services percentage (consisting of primary health care and community services) of the MOHCW expenditure remained relatively constant, but overall stayed rather at a low percentage of around 11 %. The administration and research together decreased from 14.4 % in FY 1990/91 to about 3.0 % in FY 1994/95 to 2.8 % in FY 1996/97. Under ESAP the budgets were decreased. Certain activities as community health services, research, and development surveys to monitor effectiveness of projects/programmes, including the improvement of the health care delivery system are given less priority in budgets. This originates in the fact that they have not a direct impact on health status.

Figure 21 illustrates the trend in the administration sub-unit. During 1993/94 a decline in the budget allocation is noticed which could be due to ESAP. The percentage in allocation dropped from about 14 % in FY 19990/91 to 2.3 % for FY 1993/94. Figure 22 presents the trend in the budget for the Medical care services which increased continuously even during ESAP although not with the same rate. The introduction of the users fee system during ESAP appears to have encouraged the use of curative services and decreased the demand for preventive services. Figure 23 shows the budget for the research component. Although the amount for research increases each year the percentage in the overall budget allocation is very low. Figure 24 reveals the budget over the years for preventive care services. The amount allocated to this sub section increases each year but the percentage of the total budget is actually at a status quo. Although the MOHCW is committed to the primary health care approach the allocated budget to the preventive services is still very low.

TABLE 15 : TRENDS IN ALLOCATION TO THE MAIN EXPENDITURE SUB SECTIONS FOR 1982-99

Fiscal Year	Administration	Medical Care Services	Preventive Services	Research
1982/83	6 049 800	107 389 965	17 187 546	960 000
1983/84	5 163 000	113 605 000	19 062 787	1 169 000
1984/85	7 288 200	130 899 000	22 247 000	1 055 000
1985/86	17 537 000	153 577 000	27 298 000	1 201 000
1986/87	19 010 000	195 588 000	31 861 000	1 435 000
1987/88	19 532 000	230 596 800	46 530 700	1 927 500
1988/89	40 952 000	260 792 000	53 950 000	2 275 000
1989/90	67 047 000	317 274 000	50 753 000	2 415 000
1990/91	76 773 000	412 192 000	59 132 000	2 609 000
1991/92	98 460 467	499 474 372	69 050 161	3 010 000
1992/93	75 959 000	589 300 000	110 290 000	3 135 000
1993/94	21 170 000	783 020 000	114 113 000	4 905 000
1994/95	25 720 000	905 559 000	129 565 000	5 995 000
1995/96	32 286 000	1 357 093 000	168 526 000	5 889 000
1996/97	43 184 000	1 572 412 000	186 671 000	7 890 000
1997/98	48 838 000	1 648 893 000	207 030 000	9 144 000
1998/99	53 280 000	1 957 452 000	223 126 000	9 951 000

Source : World Bank Harare for values 1982/94 and MOHCW, Finance Department for values 1995/99

TABLE 16 : PERCENTAGES OF TOTAL BUDGET SPENT PER SUB-SECTION 1990-97

Fiscal Year	Administration	Medical Care Services	Preventive Services	Research
1990/91	13.9	74.8	10.7	0.5
1991/92	14.7	74.5	10.3	0.4
1992/93	9.8	75.7	14.2	0.4
1993/94	2.3	84.8	12.4	0.5
1994/95	2.4	84.9	12.1	0.6
1995/96	2.1	86.8	10.8	0.4
1996/97	2.4	86.9	10.3	0.4

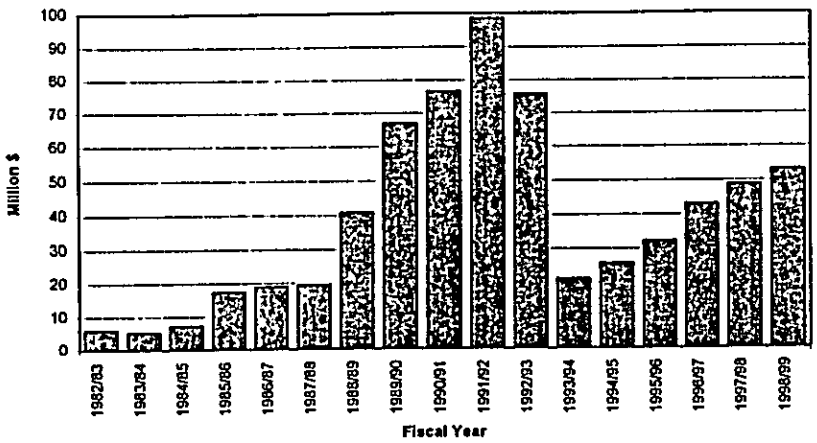

FIGURE 21 : TRENDS IN ADMINISTRATION ALLOCATION

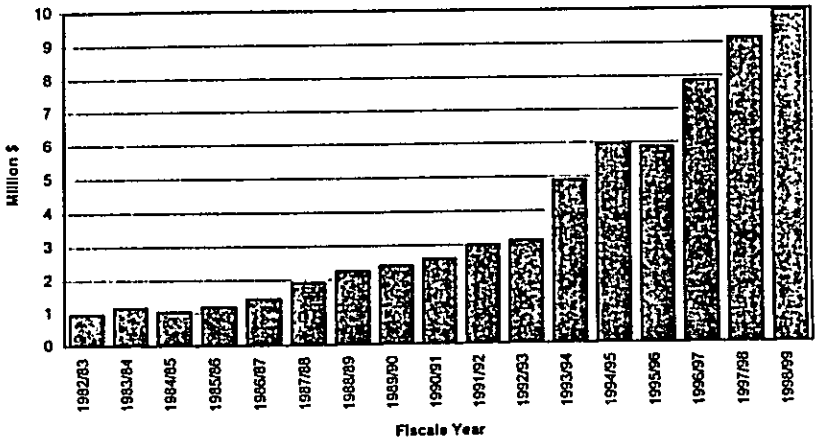

FIGURE 23 : TRENDS IN RESEARCH ALLOCATION

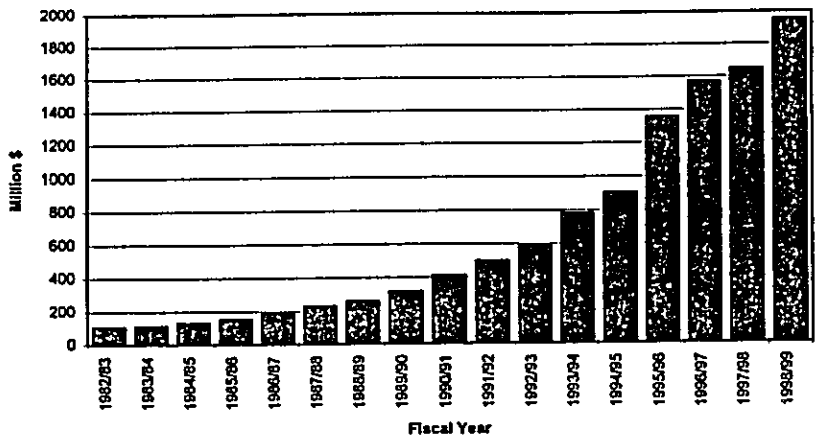

FIGURE 22 : TRENDS IN MEDICAL CARE SERVICES ALLOCATION

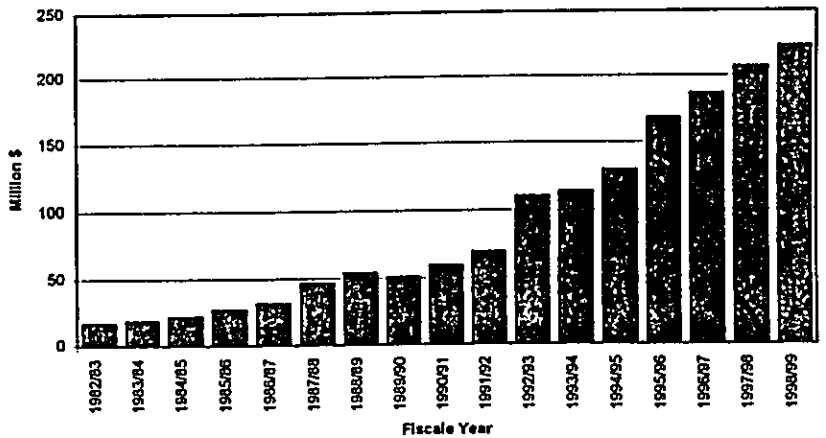

FIGURE 24 : TRENDS IN PREVENTIVE SERVICES ALLOCATION

The government health spending according to the level of services is difficult to identify because the salaries are allocated en bloc and not by institution and the grant funding is also not broken down. The district level is the lowest level cost-centre. It covers the district hospital, the clinics and RHC. The 1995 Public Expenditure Review done by the World Bank and the GOZ estimated the share of spending at different levels with an estimated spending per head by level of service as presented in Table 17. Figure 25 provides some more details on percentages for 1996-97. Of the $ 114 per head budgeted for the MOHCW about $ 74 is going towards the hospital level care and $51 is going to the provincial and the central hospitals including Parirenyatwa Hospital while the preventive services is only taking a $ 13.

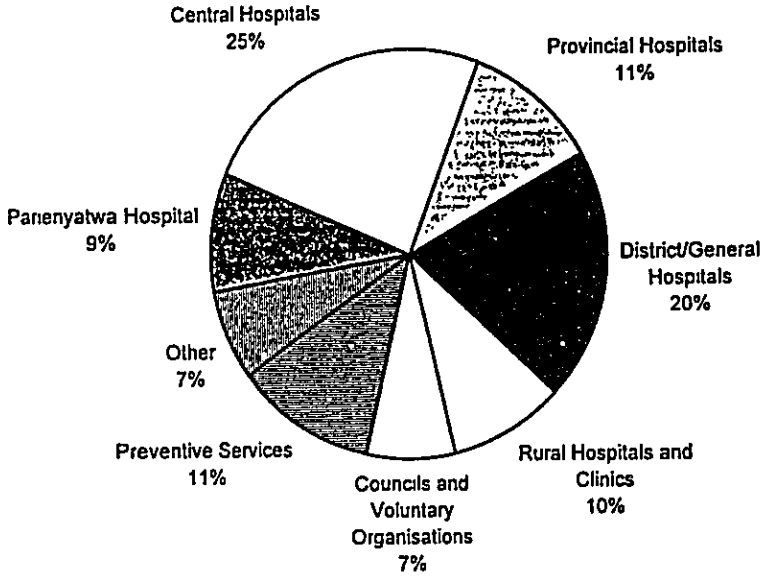

FIGURE 25 : PERCENTAGE OF THE MOHCW SPENDING ON SERVICE 1995-96

TABLE 17 : APPROXIMATE MOHCW SPENDING BY LEVEL OF SERVICE 1995-96

Level	Approximate 1994/95 share in %	Approximate spend $ per head	Approximate spend $m
Parirenyatwa Hospital	9.4	10.7	127
Central Hospitals	24.2	27.6	328
Provincial Hospitals	11.2	12.8	152
District/General Hospitals	20.0	22.8	271
Rural Hospitals and Clinics	9.5	10.8	128
Councils and Voluntary Organisations	7.2	8.2	98
Preventive Services	11.2	12.8	152
Other	7.3	8.3	99
TOTAL	100	114.2	1355

2.2. HEALTH INFRASTRUCTURE

Table 18 and Table 19 are presenting the distribution and ownership of hospitals and health centres by province as at 1993 and Table 20 and Table 21 are illustrating the distribution and ownership of hospitals and primary level health facilities per province as at 1996 (third Quarter). In 1993 there were 224 Hospitals and 1154 Health Centres including the Clinics with a total of 1378 Health Facilities while in 1996, there were 166 Hospitals and 1273 Primary Level Health Facilities with a total of 1439 Health Facilities countrywide.

Between 1993 and 1996 there is an increase of 61 health facilities noticed. Between 1993 and 1996 there is also a shift noticeable regarding the grading of rural hospitals. The rural and mission hospitals in 1993 were regarded as hospitals but in most of these facilities there were no permanent doctors based and laboratory and X-ray facilities were not available or up to standard. Under the FHP, phase I and II some of these facilities were upgraded to district hospitals and others were graded as primary level health facilities according to the MOHCW criteria and assessment. The 1996 data indicate a shift of the rural hospitals to primary level health facilities as the service delivery is not comparable with the other hospitals.

In all provinces there is a provincial hospital except for Matabeleland North where Bulawayo functions as the provincial hospital for the area. The highest amount of hospitals are found in Manicaland, followed by Masvingo and the Midlands with 40, 35 and 32 hospitals respectively in 1993 and for 1996 it shows the same trend, excluding the rural hospitals. The lowest hospital number is found in Matabeleland North and Mashonaland Central. The rural health centres and clinics are most represented in Manicaland with the Council owning 99 of the 259 RHC/Clinics in 1993, followed by the Midlands with the Council owning 68 of the 191 RHC/Clinics. The lowest amount of RHC and Clinics is found in Matabeleland North with 75 RHC/Clinics of which the Government owns 29.

Rural District Councils owned, in 1993, a 39 % or 451 of the Health Centres followed by the Government which owned 370 health centres or 32 %. The Government, Rural District Council and Mission health centres are rural based with some of the health centres in small urban areas. In 1996 the Council owned 39 % or 497 of the Health Centres followed by the Government which owned 349 or 27.4 % of the health centres. About three quarters of all health facilities are owned by the government represented by the Rural District Councils and the Central Government. This rough calculation excludes the government owned rural hospitals. The other health facilities are owned by the missions and the private sectors.

The primary level facilities include all the government rural hospitals whose bed capacity is less than 50 beds and no permanent doctor is based at these facilities. A hospital has been defined per MOHCW criteria as being any health institution with an

out patient department and an in-patient facility with an established resident medical doctor, an X-ray department and laboratory diagnostic facilities. This criteria has been applied in the 1996 tables and therefore a shift in health facilities between 1993 and 1996 per province is illustrated in Table 19 and 20.

Up until 1992 there were only 55 districts in Zimbabwe, the number has been increased to 57 with the creation of a second district by dividing Gokwe district into two and creating Umguza district by taking parts of Nyamandhlovu, Tsholotsho and Inyati. In changing these boundaries the shift in health facilities per province has been changed as well.

In the 1996 Table 20 the category of district hospitals has been split in two sub heads as district hospital and general hospital. The district hospital is situated usually in a rural area, permanently staffed by one or more physicians, providing medical and nursing care. The general hospital is providing medical and nursing care for more than one medical discipline (general medicine, general surgery, obstetrics).

A lot of Mission hospitals are functioning as district hospitals. The FHP phase II, earmarked the construction and upgrading of district level hospitals, health centres and clinics. New district hospitals have been envisaged for the Mudzi, Chivi, and UMP districts. The construction of a district hospital in Hwange under the PSIP is also been considered. Over the past decade during the FHP phase I and II, 24 district hospitals were upgraded and the work environment of health workers improved.

TABLE 18 : DISTRIBUTION AND OWNERSHIP OF HOSPITALS BY PROVINCE FOR 1993

Province	Central	Provincial	Maternity	District	Rural	Mission	Special	Other	TOTAL
Manicaland		1		5	10	21	2	1	40
Mashonaland C		1		4	3	5		1	14
Mashonaland E		1		5	10	9	1	1	27
Mashonaland W		1		5	8	5		4	23
Matabeleland N				5	5	5		2	17
Matabeleland S		1		5	6	7			19
Midlands		1	1	6	5	12		7	32
Masvingo		1		2	11	15	1	5	35
Harare C	3		1				3	1	8
Bulawayo C	3		1			1	4		9
TOTAL	6	7	3	37	58	80	11	22	224

Source : MOHCW, Report of the Secretary of Health and Child Welfare, 1993, Health Facility Forms

Note : Special hospitals include Infectious Disease and Psychiatric Hospitals
Other Hospitals include Industrial, Mine Hospitals, Private Hospitals
Harare includes Chitungwiza

TABLE 19 : DISTRIBUTION AND OWNERSHIP OF PRIMARY LEVEL : CLINICS - RHC BY PROVINCE - 1993

Province	Govt	Mission	Council	Municipality	Other	Total	Grand Total
Manicaland	62	11	99	6	41	219	259
Mashonaland C	40		42	3	13	98	112
Mashonaland E	51	10	76	3	11	151	178
Mashonaland W	34	1	57	11	24	127	150
Matabeleland N	29	2	26	2	16	75	92
Matabeleland S	32	5	31	2	22	92	111
Midlands	57	10	68	15	41	191	223
Masvingo	65	7	52		7	131	166
Harare C				45	7	52	60
Bulawayo C				18		18	27
TOTAL	370	46	451	105	182	1154	1378

Source : MOHCW, Report of the Secretary of Health and Child Welfare, 1993, Health Facility Forms

Note : Grand Total : include the Hospitals and the Primary Level Health Facilities
Other : include the Industrial, Mine and Private Clinics
Harare includes Chitungwiza

TABLE 20 : DISTRIBUTION AND OWNERSHIP OF HOSPITALS BY PROVINCE AND TYPE FOR THE THIRD QUARTER 1996

Province	Central	Provincial	Maternity	District		Mission		Special	Private	TOTAL
				General	District	Acting District	Other			
Manicaland		1		1	3	3	17	3	1	29
Mashonaland C		1		0	4	3	2		1	11
Mashonaland E		1		1	3	1	6	1	1	14
Mashonaland W		1		1	4	0	5		6	17
Matabeleland N		0		0	5	1	4		2	12
Matabeleland S		1		0	5	0	7			13
Midlands		1	1	1	5	1	11		8	28
Masvingo		1		1	1	4	13	1	3	24
Harare C	2		1					3	1	7
Chitungwiza C	1									1
Bulawayo C	2		1					5	2	10
TOTAL	5	7	3	5	30	13	65	13	25	166

Source : MOHCW, EDC-NHIS Unit, 1997
Note : Special hospitals include Infectious Disease and Psychiatric Hospitals
Private Hospitals include Industrial Clinics and Hospitals, Mine Clinics and Hospitals, Private Clinics and Hospitals

The health services provided by the Government are including Central Government (Central, Provincial, District, Maternity and Specialised Hospitals) and Local Government (Rural District Council Hospitals) for about 38 % together, while the Missions (Mission Hospitals) account for 47 % and the Private Sector (Industrial and Mine hospitals included) for 15 %.

TABLE 21 : DISTRIBUTION AND OWNERSHIP OF PRIMARY LEVEL HEALTH FACILITIES : RURAL HOSPITALS CLINICS - RHC BY PROVINCE - THIRD QUARTER 1996

Province	Rural Hospital	Government	Mission	ZNA/ZRP	Council	Municipality	Private	Total	Grand Total
Manicaland	9	59	14	3	104	6	40	235	264
Mashonaland C	3	39		4	50		9	105	116
Mashonaland E	10	41	14	2	85		13	165	179
Mashonaland W	9	32	1	3	67	11	35	158	175
Matabeleland N	6	29	2	0	27	2	18	84	96
Matabeleland S	6	40	6	7	32	2	14	107	120
Midlands	5	55	10	2	69	14	43	198	226
Masvingo	9	54	13	3	63		10	152	176
Harare C						41		41	48
Chitungwiza C						9	2	11	12
Bulawayo C						17		17	27
TOTAL	57	349	60	24	497	102	184	1273	1439
PERCENTAGE	4.5 %	27.4 %	4.7 %	1.9 %	39 %	8 %	14.5 %		

Source : EDC-NHIS Unit, 1996

Note : Grand Total : include the Hospitals and the primary level health facilities

The Government policy stipulates that at least one health facility per 6 000 to 10 000 people should be accessible in the rural areas. This target has been achieved in all provinces as illustrated in Table 22. This calculation includes the industrial, mines and private health facilities. Although not always accessible to the general public they provide health care to people working in these sectors. Although there are large variations between the districts and the provinces, the provinces with the highest number of health facilities are Manicaland (in 1993 - 259 health facilities, in 1996 - 264 health facilities) and the Midlands (in 1993 - 223 health facilities, in 1996 - 226 health facilities). The physical infrastructure for delivery of primary health care is becoming more equitable distributed when looking at the percentages of people served by the health facilities.

Although the target of at least one health facility per 10 000 people has been achieved in 1993 and 1996 the problems of access still persist. In some districts the population is scattered and many people live far away from the health facility. An indicator to calculate access to the health facility is the average number of out-patient visits per person. But, the indicators of the number of health facilities and the utilisation of them by the population still do not give an accurate picture of the quality of the provided services. Table 22 illustrate that despite the increase in the number of health facilities between 1993 and 1996, the number of people covered per health facility has increased as well, with a possible increase in workload for health personnel in these health facilities.

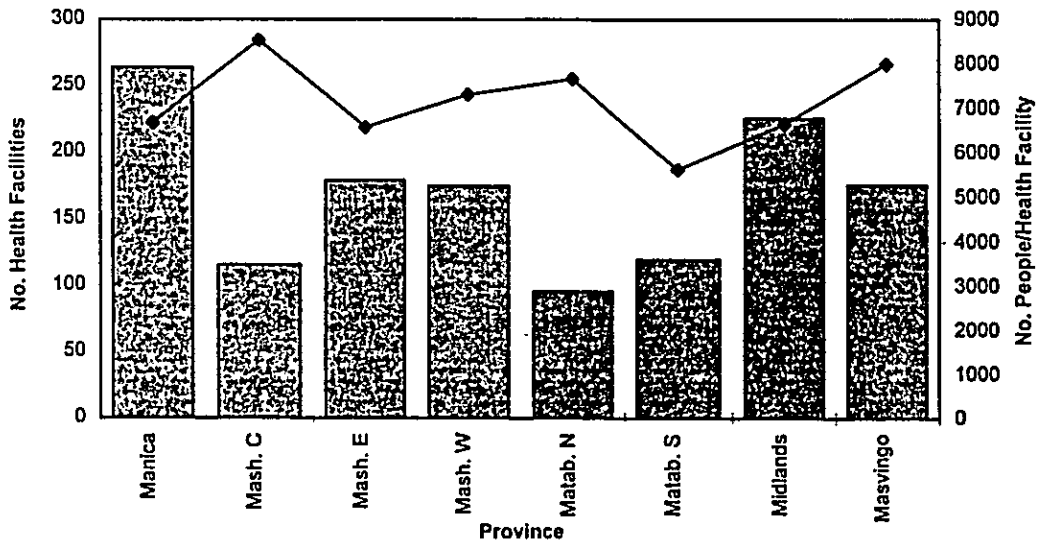

FIGURE 26 : NUMBER OF HEALTH FACILITIES COMPARED WITH NUMBER OF PEOPLE PER HEALTH FACILITY PER PROVINCE

TABLE 22 : NUMBER OF HEALTH FACILITIES, POPULATION AND NUMBER OF PEOPLE PER HEALTH FACILITY - 1993 - 1996

Province	Number of Health Facilities		Population		Number of People per Health Facility	
	1993	1996	1993 population	1996 projected population	1993	1996
Manicaland	259	264	1 608 689	1 761 000	6211	6670
Mashonaland C	112	116	910 730	989 000	8132	8526
Mashonaland E	178	179	1 174 977	1 174 000	6008	6559
Mashonaland W	150	175	1 248 639	1 277 000	7833	7297
Matabeleland N	92	96	672 069	735 000	7305	7656
Matabeleland S	111	120	624 644	674 000	6527	5617
Midlands	223	226	1 385 135	1 503 000	6211	6 650
Masvingo	166	176	1 248 639	1 406 000	7522	7 989
Harare C	60	60	1 617 871	1 709 829	26 965	28 497
Bulawayo C	27	27	644 393	716 000	23 866	26 518
TOTAL	1378	1439	10 956 628	11 944 829	7 943	8 300

Note : Harare and Chitungwiza are calculated together.
Source : MOHCW, EDC-NHIS Unit, 1996

The implication of the health sector reform on ownership of District Health Services is that all public health institutions will be owned by the Rural District Councils. They will be managed by the District Health Boards on behalf of the Rural District Councils. The Mission Health Facilities (hospitals and clinics) will remain under their present ownership although the Government pays the recurrent costs. Some Mission Authorities requested the Government to take over the ownership of their health facilities because of difficulties of funding the operational costs. After an in depth assessment of the Mission Hospitals, some will be designated as District Hospital and others may be down sized in order to be comparable with other health facilities in the district.

While the district health services will be owned by the Rural District Councils in the context of the health sector reform, there is no equivalent Local Authority to own the Provincial and Central Hospitals. Detailed studies of Provincial Hospitals, Municipality Health Services and the Rural District Council Health Services will determine the ownership and roles of each health institution in relation to the District Health Services' provision.

2.3. HUMAN RESOURCES FOR HEALTH

The overall purpose of the MOHCW is the promotion of health and quality of life of the people. The MOHCW has developed Health Human Resources policy guidelines to assist health managers in planning the human resources needs, to establish health personnel standards as well as to preview the minimum number of staff for the optimum service delivery at all levels.

The information on human resources is mostly taken from the register. It should be noted that although health workers are registered with the Health Professional Council, not all of them are practising in the field of health in the country. Since 1990 there is a remarkable movement of health staff from Government institutions to the private sector and to neighbouring countries where higher salaries are offered. Between January 1996 and April 1997, 1890 nurses resigned from government services because of poor working conditions and excessive workload (Minister of HCW statement, The Herald 30 May 1997)

With the building of new district hospitals, RHC and upgrading of other health facilities including the expanding of the services requirements under the FHP, phase II, more health personnel is needed to delivery the health services in the rural areas. A human resources development plan has been instituted and training was increased but there is still a deficit in the human resources for health. It was observed that the second level of nurse training had become redundant and the training of State Certified Nurses ceased in 1992. Although the output of General Nurses has increased slightly since Independence the cessation of the State Certified Nurse Training had an adverse impact on the total number of graduates entering the government services.

The personnel department has computerised records of the health care workers. The Health Professions Council is in the process of entering data on all personnel registered with the Health Professions Council. There is a need to research more in depth on the strengthening of human resources for health and the general civil services reforms towards the local authorities.

Assessing health resources requirements has been determined by applying the WHO norms formula (staff per 100 000 population). This has not been the most appropriate method to determine staffing patterns in the country. Besides the basic staffing patterns, degrees of workload have been added to determine a strategic minimum in Zimbabwe. Table 23 presents the population for selected health personnel ratio for 1993 and 1996. The cadres presented are the medical practitioners represented by the doctors in the country. The dental staff is represented by the dental practitioners and the dental therapists together. There are also the dental technologists but they are not included in the calculation. The general nurses are presented as a cadre on its own as well as the state certified nurses excluding the state certified traumatology and maternity nurses. In the rehabilitation staff the following categories have been included : physiotherapists, occupational therapists, speech therapists, rehabilitation technicians as well as the

orthopaedic technologists and technicians. The environmental staff is presented in the calculation as environmental health officers and technicians together. The laboratory staff represents the medical laboratory technologists and the technicians.

The pharmacy staff represents the pharmacists and the technicians while the X-ray staff is the group of radiographers and X-ray operators together. These cadres are according to their training assigned to the appropriate level of health care provision.

Table 23 illustrates that in 1993 the population served per dental staff was 55 562 : 1 dental staff, taking into consideration that both categories were used for the calculation. If only the dental practitioners would be used in the calculation, the ratio would have been 78 108 : 1 dental practitioner for 1993 (WHO classification one dentist per 100 000). For 1996 the ratio became 85 934 : 1 or per dentist an increase of 11%. Although this classification seems to express the idea that the population per health staff is average, it need to be pointed out that the health workers registered are not always working in the public sector or in the rural areas where most people are living. Therefore the calculation done for the provinces and cities separately gives a better picture for the population - health workers ratio as seen in Table 25.

TABLE 23 : THE POPULATION FOR HEALTH PERSONNEL RATIO FOR 1993 and 1996

Health Personnel Category	Number		Population/ Health Personnel Category	
	1993	1996	1993	1996
Medical Practitioners	1 551	1 387	6 950	8 612
Dental Staff	194	193	55 562	61 890
General Nurses	6 526	7 444	1 652	1 605
State Certified Nurses	9 234	7 411	1 167	1 612
Rehabilitation Staff	405	417	26 615	28 645
Environmental Health Staff	1 166	1 096	9 244	10 899
Laboratory Staff	510	445	21 135	26 842
Pharmacy Staff	638	628	16 894	19 021
X-Ray Staff	195	223	55 277	53 564

Source : MOHCW, EDC-NHIS Unit, 1997
Health Professions Council 1993-96

Population 1993 : 10 778 964 (based on the 1992 census estimates)
Population 1996 : 11 944 829 (based on the 1992 census estimates)

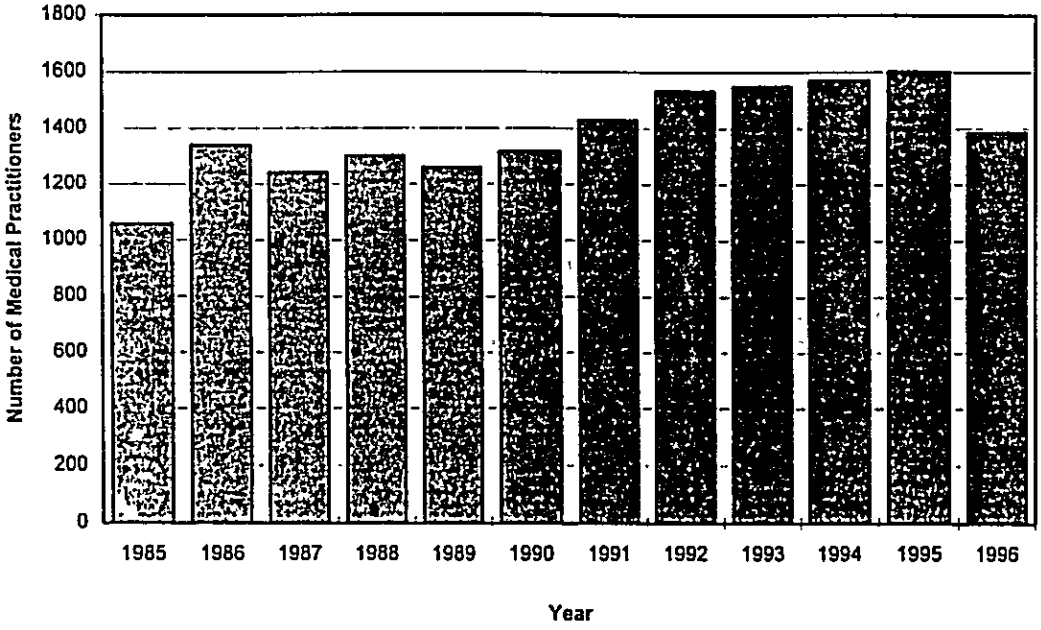

FIGURE 27 : NUMBER OF MEDICAL PRACTITIONERS REGISTERED 1985-96

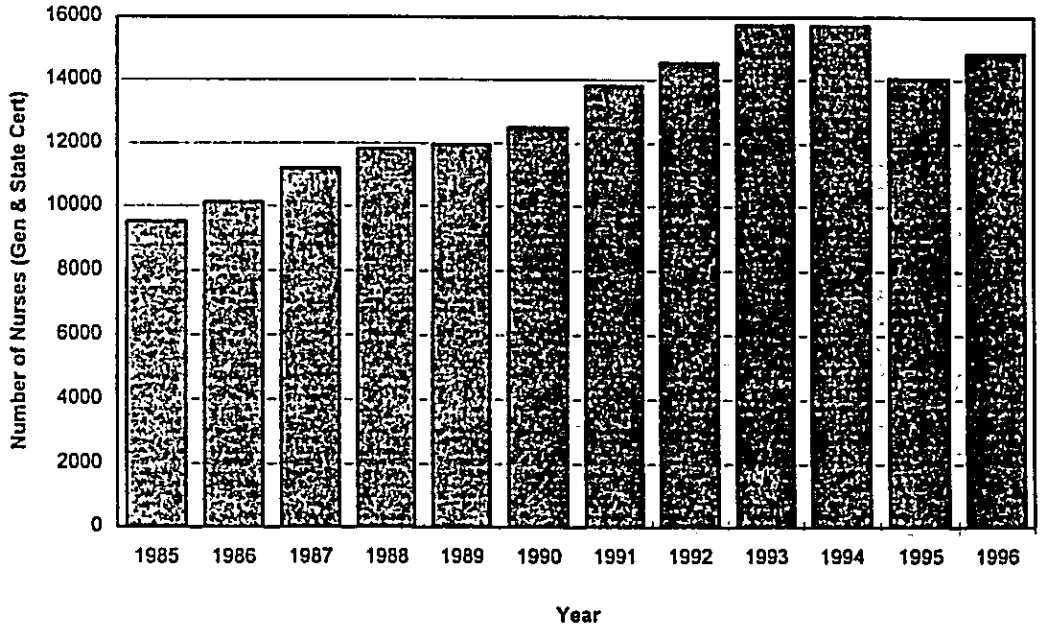

FIGURE 28 : NUMBER OF GENERAL & STATE CERTIFIED NURSES REGISTERED 1985-96

TABLE 24 : NUMBER OF HEALTH PERSONNEL REGISTERED BY CATEGORY 1985-1996

CATEGORY	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Medical Practitioners	1058	1342	1243	1303	1261	1320	1431	1534	1551	1572	1603	1 387
Dental Practitioners	94	133	113	122	113	131	125	132	138	139	152	139
Pharmacists	285	327	323	354	352	347	387	413	441	476	499	441
Physiotherapists								118	127	135	164	141
Occupational Therapists							35	36	39			52
Speech Therapists							12	17	17			15
Orthopaedic Technologists							23	25	25			24
Rehabilitation Technicians							190	181	185			176
Orthopaedic Technician							11	11	12			9
Opticians	40	48	43	45	42	44	50	33	52	54	54	31
Psychologists	30	43	46	52	48	46	53	63	67	79	85	69
Radiographers	98	121	140	161	169	166	160	150	158	162	204	181

CATEGORY	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
X-Ray Operators							44	36	37			42
Medical researchers	7	11	10	10	12	11	13	14	14	24	30	27
• General Nurses							6 224	6 337	6 526	7 185	7 188	7 444
• State Certified Nurses							+7 603	+8 223	+9 234	+8 548	+6 876	+7 411
Nurses (Gen. & State Certif.)	9 533	10 131	11 206	11 830	11 956	12 518	13 827	14 560	15 760	15 733	14 064	14 855
Midwives	3 039	2 444	2 512	2 496	2 627	2 651	2 777	2 825	2 894	3 038	3241	3 088
State Certified Maternity Nurses							3 829	4 173	4 190	4 617		4 308
Psychiatric Nurses							410	419	437			444
Paediatric Nurses							7	8	9			11
State Certified Traumat. Nurses							231	285	300			209
Pharmacy Technicians	91	118	138	163	148	159	172	192	197	190	204	187
Dental Technicians	14	26	21	27	20	22	21	22	24	35	33	30

CATEGORY	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Dental Therapists							54	56	56			54
Laboratory Technicians		161	166	175	180	-	-	191	214	215	225	186
Medical Laborat. Technologists	150	145	170	194	186	168	257	279	296	299	318	259
Blood Transfusion Technicians				24	22	20	20	21	21	18	20	14
Environmental Health Officers	77	102	118	143	151	145	160	167	185	188	185	159
Environ. Health Technicians	360	545	592	599	706	796	953	976	981	1050	878	937
Dieticians							12	14	14			9
Clinical Social Workers								10	11			15
Clinical assistants		21	18	10	19	22	22	24	24	21	13	15

Source : Health Professions Council of Zimbabwe, 1985-96

TABLE 25 : DISTRIBUTION OF SELECTED HEALTH PERSONNEL BY PROVINCE, DECEMBER 1995

Health Personnel		Manicaland	Mash. C.	Mash. E.	Mash. W.	Masvingo	Mat. N.	Mat. S.	Midlands	Total
Doctors		21	21	25	28	37	12	20	36	200
Nurses		637	324	483	577	555	289	583	797	4245
Dental	Doctors	2	1	1	2	3	2	1	2	14
Staff	Dental Therapist	5	1	4	5	6	4	3	5	33
	Total	7	2	5	7	9	6	4	7	47
Rehab.	Therapists	6	1	8	5	4	0	1	5	30
Staff	Technicians	12	24	20	19	19	10	12	19	135
	Total	18	25	28	24	23	10	13	24	165
Environ	En. H. Officer	6	7	13	6	11	6	7	13	69
Staff	En. H. Techn.	135	94	106	68	130	66	76	102	777
	Total	141	101	119	74	141	72	83	115	846
Lab.	Lab. Technol.	2	1	2	4	6	1	3	9	28
Staff	Lab. Techn.	8	12	5	7	12	5	8	9	66
	Total	10	13	7	11	18	6	11	18	94
Pharm.	Pharmacists	5	2	4	3	4	1	2	6	27
Staff	Pharm. Techn	8	6	8	8	8	6	8	13	65
	Total	13	8	12	11	12	7	10	19	92

Health Personnel		Manicaland	Mash. C.	Mash. E.	Mash. W.	Masvingo	Mat. N.	Mat. S.	Midlands	Total
X-Ray	Radiographers	6	4	4	2	3	0	2	5	26
Staff	X-Ray Operat.	3	2	4	3	2	3	7	8	32
	Total	9	6	8	5	5	3	9	13	58
Total Prov. H. Workers		1 776	1 099	1 318	1 468	1 574	1 013	1 050	1 834	11 132
Population		1 704 000	956 000	1 140 000	1 235 000	1 369 000	712 000	653 000	1 450 000	9 212 000
Pop./1 Doctor		81 143	45 524	45 600	44 107	36 730	59 333	32 650	40 360	46 060
Pop./1 Nurse		2676	2 951	2 860	2 140	2 449	2 464	1 120	1 823	2 170
Pop./1 Dental Staff		343 429	478 000	226 000	176 429	161 000	118 667	163 250	207 571	196 000
Pop./1 Rehab. Staff		94 667	38 240	40 714	51 458	69 087	71 200	50 231	60 542	55 830
Pop./1 Environ. H. Staff		12 086	9 465	9 580	16 689	9 638	9 889	7 867	12 635	10 889
Pop./1 Laboratory Staff		170 400	73 538	162 857	112 273	75 500	118 667	59 364	80 722	98 000
Pop./1 Pharmacy Staff		131 077	119 500	95 000	112 273	113 250	101 714	65 300	76 474	100 130
Pop./1 X-Ray Staff		189 833	159 333	142 500	247 000	271 800	237 333	72 556	111 769	168 828

Source : Provincial Staff Records, 1995

Note: Mine, Industry and private facilities are not included, nurses in mission and council institutions are excluded. Population projected for 1995.

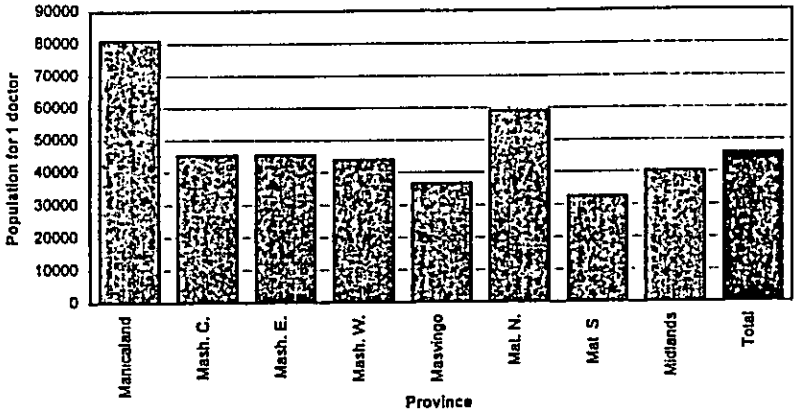

FIGURE 29 : POPULATION FOR ONE DOCTOR PER PROVINCE

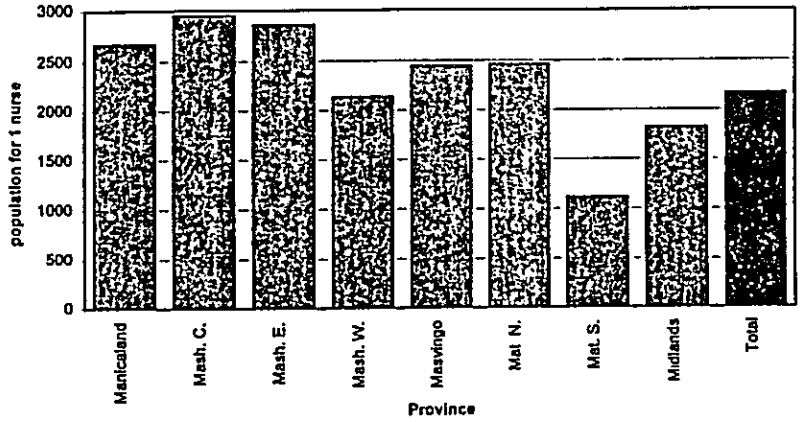

FIGURE 30 : POPULATION FOR ONE NURSE PER PROVINCE

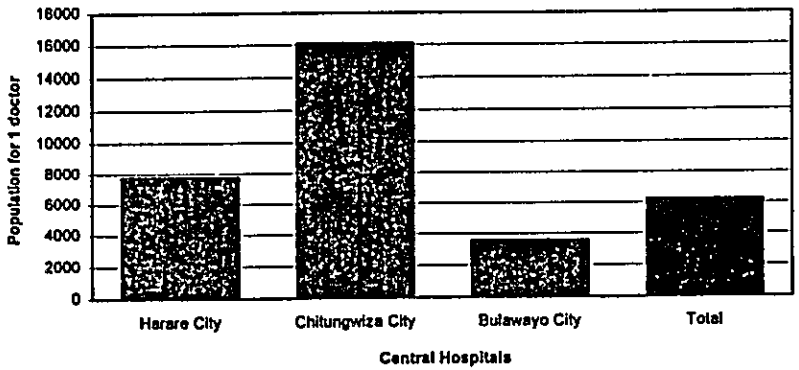

FIGURE 31 : POPULATION FOR ONE DOCTOR PER CENTRAL HOSPITAL

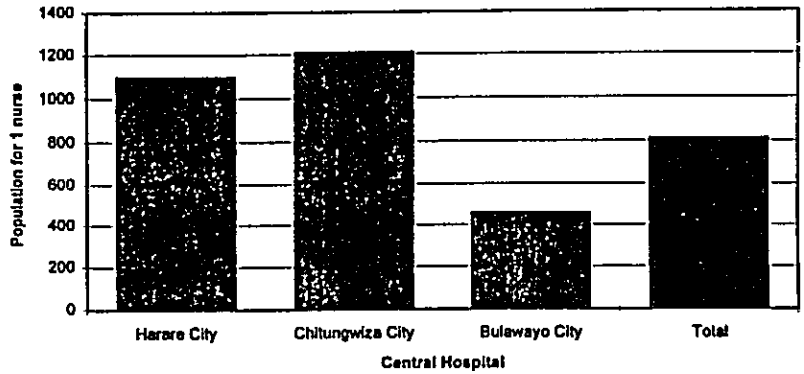

FIGURE 32 : POPULATION FOR ONE NURSE PER CENTRAL HOSPITAL

TABLE 26 : DISTRIBUTION OF SELECTED HEALTH PERSONNEL BY CENTRAL HOSPITALS, DECEMBER 1995

Health Personnel		Harare City	Chitungwiza City	Bulawayo City	Total
Doctors		212	19	193	424
Nurses		1506	253	1504	3263
Dental	Doctors	-	2	-	2
Staff	Dental Therapist	-	-	2	2
	Total	-	2	2	4
Rehab.	Therapists	19	4	8	31
Staff	Technicians	21	6	10	37
	Total	40	10	18	68
Environ	En. H. Officer	-	-	-	-
Staff	En. H. Techn.	-	-	-	-
	Total	-	-	-	-
Lab.	Lab. Technol.	116	3	41	160
Staff	Lab. Techn.	14	5	23	42
	Total	130	8	64	202
Pharm.	Pharmacists	18	2	12	32
Staff	Pharm. Techn	16	3	14	33
	Total	34	5	26	65
X-Ray	Radiographers	53	6	19	78
Staff	X-Ray Operat.	-	-	14	14
	Total	53	6	33	92
Population		1 653 835	305 990	692 000	2 651 825
Pop./1 Doctor		7 801	16 105	3 585	6254
Pop./1 Nurse		1 098	1 209	460	813
Pop./1 Dental Staff		-	152 995	346 000	662 956
Pop./1 Rehab. Staff		41 345	30 599	38 444	38 997
Pop./1 Environ. H. Staff		-	-	-	-
Pop./1 Laboratory Staff		12 722	38 249	10 813	13 128
Pop./1 Pharmacy Staff		48 642	61 198	26 615	40 797
Pop./1 X-Ray Staff		31 204	50 998	20 970	28 824

Source : EDC-NHIS Unit, 1996

Note : For Harare : Parirenyatwa and Harare Hospital are put together, for Bulawayo : Mpilo, UBH and Ingusheni are put together. Population projected for 1995

Table 24 and Figures 27 and 28 present the health categories registered from 1985 until 1996. Although the trend is increasing for almost all health personnel, except for 1996, it is difficult to estimate how many of the cadres are effectively working in the health sector as data of both private and public institutions are changing frequently. The Ministry of Health has an establishment of 23 000 which remained roughly constant over the years. Total registered health manpower in the country in 1995 numbered 29 625 with key categories presented in the same Table.

In the context of the health sector reforms and the decentralisation process, the MOHCW Civil Servant Staff will be reduced from almost 23 000 to 2518 because the health staff will become part of the District Health Staff and not any more Civil Servants. The MOHCW Headquarters and PMD staff will remain the only Civil Servants.

The excessive clustering of human resources in the urban areas can be noticed in Tables 26 which illustrates that the urban areas have much higher ratios of health professional staff than the rural areas were 80% of the population lives. There are also deficits between the primary and tertiary institutions in relation to demands for their skills and services which can also be observed in Table 25.

The dental staff per population in the provinces is an example of the mal-distribution between urban and rural areas. In Mashonaland Central, the availability of dental staff per population is 478 000 : 1 dental staff. The Manicaland and the Midlands provinces reveal that this ratio is more than 200 000 : 1 dental staff. If only the dentist is used in the ratio calculation for those provinces, the ratio is even much higher. This illustrates a total different picture than the overall availability of dental staff per population as illustrated in Table 23. The same observations can be pointed out for the laboratory staff, pharmacy staff, rehabilitation staff and X-ray staff.

The MOHCW Human Resources Master Plan (1993-1997) makes a comparison between the number of actual posts in the MOHCW health care delivery system and the optimal. There is a need for additional doctors, nurses, pharmacists, laboratory staff, which is also observed in Table 25 where the population per health staff is very high for the provinces. The constant brain drain of doctors and nurses and other health professionals to other countries with better salaries, working conditions and the reluctance to work in rural areas, puts the MOHCW in a difficult position to offer quality of services at the expanding health facilities. The MOHCW introduced result based staff appraisal systems and adjusted the curricula for the training of health personnel to the changing health care needs in order to better serve the people and provide quality care.

3. MONITORING AND EVALUATION

3.1. NATIONAL HEALTH MONITORING MECHANISM

The objective of public health and demography is looking for objective measures of the health status of a population in the community or nation as a whole. The planning and management of a public health service system at any level requires the support of a disease and health surveillance system. The surveillance system should include a health information system. Monitoring and evaluation of health programmes and initiatives cannot be effectively executed without the support of patient medical record systems, reporting systems and health indicators.

The monitoring of the health care delivery system is the overall responsibility of the Epidemiological and Disease Control Services including the National Health Information Systems Unit. One of the other supporting systems to collect data is the vital registration system which is in place nation wide and decentralised to the district level. One of the NHIS priorities related to the vital registration 1996-2000 is the establishment of community based mortality data collection at all provinces with increasing the speed of the deaths coding.

3.1.1. Vital Registration System

The Central Statistics Office (CSO) is in charge of the vital statistics which are obtained through :

- civil registration system
- population census and surveys
- administration records from maternity hospitals, health centres, clinics and other health related institutions

The use of the vital statistics are varied with the provision of social safety nets for the disadvantaged groups, the planning of other social services, the implementation of the insurance policies, being a few.

The vital civil registration system and the vital statistics started in Zimbabwe in 1890 with the introduction of formal enactment and regulating processes related to deaths and births. The first census was done in 1962 followed by one in 1969, however these two censuses were done for different population groups at different times using different type of questionnaires. The 1982 census was the first census done for the whole population with the same criteria. The 1992 census was the latest population census. The Census and Statistics Act of 1971 was put in place to provide a legal framework in which the taking of census, collection of statistics and publication of statistical information is legalised.

The administrative structures of the vital registration system are divided over the 10 provinces and subdivided in the 58 administrative districts with the Registrar General's Department, the head office in Harare. The MOHCW, through its institutions such as the maternity hospitals, clinics and other hospitals where deaths and births are recorded, is a collaborating partner in the recording of the vital events.

The full coverage of the civil registration system however has been hampered by the ignorance of the population regarding vital registration, lack of manpower for manual recording, delayed publications and the fact that the actual registration of vital events is done in the office of the Registrar General, based in the Ministry of Home Affairs in Harare.

The CSO is responsible for the coding, data entry, tabulation and analysis of the vital statistics including the publication of the reports. They are also responsible for the population census and the surveys. The CSO staff in the Health Statistics Section extracts the vital statistics in relation to deaths, births, fertility, martial status, from the coded Notification Forms. Not much publication has been done from the vital registration information because of the backlog in manual coding according to the WHO classification (ICDS). The production of reports has not been consistent as most data although available has not been analysed. The coverage of the vital registration system is low and estimated at 25%. The system only works well in the urban areas.

The other sources of vital information through the census and surveys on mortality, fertility, marital status, births are available and timely and therefore more appropriate to be used for data analysis and trend observations.

3.1.2 Health Indicator Monitoring

Apart from the traditional measures of data collection to monitor health status, the MOHCW has identified, after long consultation in provinces, cities, health services directorates and departments, a set of health indicators emphasising the national local context. The tested health indicators are forming a reference for the development of a base-line, comparing analysis and evaluation mechanisms for planning and management. They aim at monitoring the country's health status and health systems performance. The WHO has defined an indicator as a quantitative or qualitative variable that assist in the measurement of a change at any level of performance. In the process of the search for indicators of health status a lot of issues need in depth clarification such as sources of information, type, subject and dimension of measurement etc.

It should be noted that indicators are not to be confused with objectives and targets. Objectives are expressing quantitative statements of health improvements or disease reduction. The targets are expressed in desired service performance while indicators are indirect measures of health events, service performance, resource availability monitoring health status and progress towards health goals.

The MOHCW developed a Health Services Indicator Handbook for health managers at different levels as a reference and facilitating tool for future health planning and management. This set of monitoring tools will assist in a sound health information system particularly in a period of national health reforms and the decentralisation of the health care system.

The National Health Information Steering Committee is responsible for the development of the Health Indicators possibly to be used for the monitoring of the health programmes and projects as well as for the future health management reporting system. Four areas of health indicators were developed :

- Health Status Indicators
- Resource Indicators
- Health Service Utilisation Indicators
- Quality of Care Indicators

3.1.3. HFA Monitoring Exercise : 1991- 1993- 1995

This monitoring exercise is performed every two years. The last one was in 1995.

By resolution WHA 34.36 (1981) countries decided to report to WHO on monitoring the progress and evaluating the effectiveness of the national strategies at regular intervals. Selected information concerning the main components of the 'health for all' strategy and the global indicators is collected, analysed and synthesised.

Zimbabwe integrated the monitoring and evaluation process for health for all within the managerial process for national health development and utilises the relevant information for reports to re-orient and adjust health policies and strategies. The reports are also presented at the WHO Regional Committee Meetings.

The global indicators are related to :

- national health policy and strategy development
- the involvement of people and communities in the implementation of strategies
- the percentage of national expenditure devoted to local health care, percentage GNP spent on health
- equitable resource distribution for PHC
- the amount of international aid received or given for health
- the percentage of population covered by PHC with the following :
    - * safe water and sanitation
    - * infant immunisation
    - * pregnant immunisation
    - * local health care including the availability of essential drugs within one hour walking distance
    - * ANC

    - PNC
    - delivery attendance
    - infant care
    - family planning
- the global indicator on nutrition with :
    - low birth weight and weight for age measures
- infant mortality rate
- maternal mortality rate
- probability of dying before the age of five
- life expectancy
- adult literacy
- per capita GNP

The third evaluation of the implementation of the Global strategy for HFA was conducted in 1995/96. The global indicators in relation to the Health for All evaluation were assessed and some of the trends are mentioned as an illustration :

- trends in policy development : the country's policy is aiming at equity in health and improving the quality of life through the health sector reforms. The guiding principles are decentralisation, health financing reforms, regulation of the private health sector and contracting out
- the government is also committed to the provision of basic health services with the following district core health services : EPI, IEC, reproductive health and FP, essential drugs, nutrition, epidemiological surveillance, environmental health, water and sanitation, manpower planning and training
- the indicator related to the literacy rate was found to be 80% in Zimbabwe
- the government spending on health declined from 3.0 % to 2.2 % of GDP
- the indicators of water and sanitation were found to be about 99 % for urban areas, for rural water about 70 % and for rural sanitation around 53 %
- the ANC coverage is around 93 %, TT coverage is 56%, FP is used by 48% of women

The other indicators have also been discussed at large in the previous volume.

3.1.4. Household Surveys using the WHO/AFRO 27 Indicators

Three surveys were conducted : one in 1988, another in 1990 and the third one in 1993. As documentation of the 1988 survey could not be traced, the last documented survey of 1993, which is the third in a series, is briefly explained in terms of monitoring mechanism and the second one is mentioned under the section of PHC evaluation of 1991.

The District Household Survey for Monitoring Progress Towards Health for All by the year 2000 was done in 1993 with the report being published in 1994. This survey was done in follow-up on the previous surveys done in 1988 and 1990. The main

objective of the survey was to monitor the levels and trends in health indicators in the rural areas. The parameters were : immunisation coverage, literacy rates, supply of essential drugs, adult mortality, maternal health services and family planning, community indicators, housing and sanitation and geriatric services.

These surveys were done to investigate the progress made by the different health programmes which were implemented by the Government in collaboration with other organisations involved in the health projects.

Data from 55 rural districts (5 500 households- 100 households in each of the 55 districts) were collected on the 27 WHO Health Indicators through questionnaires and interviews. The results were further published and disseminated in order to enable the health planners to evaluate the achievements that have been made towards the Health For All Strategy. The surveys are of an inter-disciplinary nature involving the communities.

3.1.5. Weekly Surveillance (WS)

In 1991, a Rapid Notification of Diseases on Special Surveillance (RNDSS) or shortly Weekly Surveillance (WS), based on the weekly reporting of 12 diseases and conditions from selected number of health centres, was established.

In 1992 due to the drought, four malnutrition conditions were added to the monitoring system. The system was used for collection of data with a special attention to the quick and timely detection of outbreaks. However the effectiveness of the system was questioned as although the detection of outbreaks was done, trends of conditions could not be followed. After discussions at a National Seminar on nutrition monitoring and evaluation (1992) and the National Annual NHIS Conference (1992) a revision of the system was executed and recommendations were formulated. After the Cholera experience in November 1992, the weekly reporting system was officially established. The WS of seven diseases (diarrhoea, malaria, measles, rabies, dysentery, acute flaccid paralysis, neonatal tetanus) is not following the national notifiable diseases list (17 diseases, notified through T1 Form), however it is a flexible system allowing any communicable disease of public health danger to be monitored and reported. In this case the plague epidemic of 1994 and the anthrax cases in 1995 were followed through the system.

At the end of 1992, 30 % of the existing health institutions were participating in the network. The expansion of the reporting system could only be executed if the criteria of a working communication system by radio, telephone, fax or E-mail was in place. By 1995, 40 % of the total RHC/Clinics and 72 % of the total hospitals were participating in the reporting network. In 1991, 14 outbreaks were reported and in 1994, 52 epidemics were notified through the system which proves that the WS system had an impact on disease control measures.

Since 1994 a Weekly Report Bulletin is produced and disseminated to the periphery and relevant health related organisations and sectors.

3.1.6. Sentinel Surveillance

The Ministry of Public Service, Labour and Social Welfare (MPSLSW) was tasked with the implementation and monitoring of the Social Dimensions of Adjustment (SDA) programme which is a component of ESAP. The periodic sentinel surveys of households and key institutions such as primary schools, health institutions, shops are meant to monitor the effects of measures introduced under ESAP on people's welfare and the availability, affordability, accessibility of basic goods and services. This is done in technical and financial collaboration with UNICEF. Up until 1996 there were six rounds of the sentinel surveillance. The health related data arising from these surveys are used to take appropriate measures in the health services delivery system.

3.2. NATIONAL HEALTH EVALUATION MECHANISM

In the MOHCW there are a number of evaluations carried out since Independence evaluating the health services. Several PHC evaluations were conducted (1984 - 1987 - 1991). Community based surveys related to MCH/FP were carried out at regular intervals (1984 - 1988 - 1991 - 1997). The CSO population censuses of 1982 - 1992 have investigated health related information on mortality of the child and the mother, literacy, water and sanitation. The CSO provided also valuable health information through the Zimbabwe Demographic Health Survey of 1988 and 1994.

3.2.1. PHC Evaluations 1984 - 1988 - 1991

3.2.1.1. The 1984 PHC Evaluation

Joint evaluations (GOZ, SCF(UK), SIDA, UNICEF, WHO) of the Primary Health Care programme were undertaken at regular intervals. The 1984 evaluation was executed to determine the progress achieved in the implementation of the PHC programme and its priorities in order to develop a future action plan. This two phased evaluation concentrated firstly on the community health care and the Village Health Workers and in its second phase the evaluation focused on the managerial aspects of the PHC programme as well as on selected specialised health programmes such as MCH/FP, Nutrition, EPI, CDD, Essential Drugs, Water and Sanitation, Malaria and Schistosomiasis. The evaluation mission reviewed reports, plans and records of the MOHCW. In using questionnaires they collected data on management procedures in seven provinces and fourteen districts. The WHO/EPI methodology was used for a field survey related to the immunisation coverage which included the assessment of the nutritional status of children below five years.

The major results and recommendations of the evaluation mission were documented as follows :

- the MOHCWs' commitment to achieve the goal of Health for All through PHC was formulated in the national health policy aiming at the equitable distribution of health care emphasising community participation
- priority programmes were identified, national targets formulated, staff was reoriented through training and curricula were adapted towards the implementation of the new policy
- the process of the management decentralisation, the integration of curative and preventive activities were in their implementation phase
- the rural communities were provided with VHW, the health services were extended through outreach activities and the increase of the health facilities in the rural areas
- the development of the EPI programme was progressing well during that time with a cold chain system established, no real shortages of vaccines were observed and staff training was provided in the technical and the cold chain management
- the outreach services for EPI were established and the immunisation coverage showed a 87 % coverage of at least one immunisation and a 42 % of fully immunised children in the 12-23 months age group
- a pharmaceutical policy based on selected essential drugs was being formulated and the shortages of drugs became less frequent
- the control of diarrhoeal diseases' training was carried out for health staff and VHW and IEC material was distributed to the communities with the result that 80 % of the interviewed mothers was knowledgeable about ORT
- the development of the MCH services was progressing well resulting in 89 % of the mothers of the index children receiving ANC and 81 % of the index children having a child health record
- 82 % of the children were weighed twice during infancy and 96 % were breast fed until 12 months
- oral contraception was known by 69 % of the mothers interviewed during the evaluation mission
- malnutrition (48 %) was still a problem for the children aged 12-59 months of age
- the programmes related to malaria, schistosomiasis, water and sanitation were formulated

During the evaluation mission it was noted that the motivated women and the peripheral health staff contributed to the PHC achievements. However the farm areas were still lacking the basic health care services. The PHC evaluation of 1984 identified the district level as key level for the implementation and management of primary health care programmes.

Recommendations were made by the evaluation team related to :

- the health policy dissemination to the provincial and senior management
- the managerial process of the PHC programmes
- the supervision and support to health care providers
- the re-orientation of the health information system
- the human resources development and manpower planning
- the strengthening of the community participation in health work
- the establishment of inter-sectoral collaboration
- the co-ordination within the MOHCW departments
- the strengthening of the health education component of PHC

Specific recommendations were made for :

- the MCH programme in relation to target setting for ANC and child care
- the CDD programme in relation to the IEC messages for ORT
- the EPI programme related to the immunisation schedules
- the essential drugs programme in relation to the list of essential drugs and training
- the programmes related to schistsomiasis, water and sanitation, and nutrition, in relation to the strengthening of the surveillance system and implementation of the programme including the target setting

3.2.1.2. The 1987 PHC Evaluation

The second joint evaluation of the PHC was done in collaboration with the same partners as the first one. In addition Botswana and Swaziland were represented in the team. The second review was a follow up of the first one in order to assess the development of selected components of the PHC approach such as the managerial aspects of MCH, Nutrition, EPI, CDD programmes. The PHC activities were evaluated at all levels of implementation. Prior to the evaluation several surveys had been conducted in the country covering a diversity of aspects related to PHC programme implementation.

The results of the 1987 PHC evaluation at the various levels were formulated as follows :

3.2.1.2.a. *For the National Level*

It was found that the process of decentralisation with the formation of development committees at the primary level, was progressing since the last review in 1984. The concept of PHC was known at all levels and the progress in EPI was remarkable with two thirds of the children being fully immunised as observed from the community based survey conducted in 1986/87. The CDD programme achieved a 90 % of ORT knowledge by mothers with two thirds of the mothers being able to prepare the solution correctly. The growth monitoring was progressing well with 50 % of the children being weighed six times in the first year. Three out of five

deliveries where conducted in the health facilities. The essential drug programme was operational. The new problems of ARI and AIDS were noticed to be new burdens on the health care delivery. Although the PHC progressed well, the health information system was insufficient at all levels for the monitoring of PHC activities. The shortage of staff for the PHC implementation and the lack of appropriate training was noted by the PHC evaluation team as well as the lack of inter-sectoral collaboration. The IEC component of PHC did not receive the strengthening it required for full operation. The programme of CDD needed to be intensified as diarrhoea was top cause of morbidity and mortality in children.

The recommendations formulation by the PHC review team were related to :

- intensified training in management skills
- specific training for the new programme activities in EPI, ARI and AIDS
- the establishment of managers posts for the EPI, ARI, AIDS programmes
- the health information system in need of action oriented training
- the establishment of an inter-sectoral body for health development for the co-ordination of the health related activities
- the IEC component requiring sufficient staff to incorporate the new demands for programme strengthening in EPI, ARI and AIDS

3.2.1.2.b. *For the provincial level*

The evaluation team found a well informed team about the health policy related to PHC. The major constraints to the service delivery was the staff shortage and the high turn over of senior professionals. With the in-adequate technical support and shortages of other resources, the health care delivery and management system at the provincial level was lacking and some of the districts were under-served with the health conditions on the farms being neglected. The inter-sectoral collaboration at the provincial level was established but needed strengthening in planning and decision making. The decentralisation process of the management and planning responsibilities were only partially done to the provinces.

The recommendations for the provincial level were that :

- the deployment of professional staff was first priority to be able to provide the health services and management support to the under-served districts
- the decentralisation process needed to be fully implemented to the provincial level

3.2.1.2.c. *For the district level*

The evaluation team found that the district staff was not very conversant with the national PHC policy and strategies and that there was insufficient supervision, lack of appropriate management and supervisory skills due to lack of appropriate training. The involvement of the DHE was lacking in the existing system and the health information system was inadequate and unreliable.

The recommendations were that all these hindering aspects needed urgent reversal in order to be able to implement the PHC approach.

3.2.1.2.d. *For the Municipal Level (City Health Departments and Clinics)*

It was noted that although the new directions of the health policy and PHC strategies were practised, the catchment area was not clear and the EDLIZ as well as the Nutrition Policy were not catering for the needs of the urban referral centres. At all levels the problems of ARI, STD, and AIDS were becoming common causes of out-patient attendance. The staffing was adequate but because of the new arising health issues the staff needed expansion. More information was required to deal with dental and mental health as well as with the ARI, STD, AIDS problems. At this level the participation of the community was lacking.

The evaluation team formulated the recommendations for this level as :

- adaptation of the training for better health care provision in relation to new situations and diseases
- the development of a communication system for data utilisation between the different levels of operation
- more expansion to the communities through out-reach and establishing community committees
- review of the nutrition policy and the adaptation of the EDLIZ to include urban related situations

3.2.1.2.e. *For the Health Centre Level*

The evaluation team found that the PHC activities were established in previously neglected areas but that the high staff turn-over including their shortage, the lack of transport and essential drugs were hindering the implementation of the PHC activities. The health information system was inconsistent and needed strengthening.

The overall recommendations for the RHC was that :

- appropriate training and the creation of incentives for working in remote areas should be provided in order to make the PHC activities consistent and reliable

The evaluation team evaluated also the health workers performance in the delivery of PHC activities such as the nurses, traditional midwives (TM), the village health workers (VHW) and the community at large in the participation in PHC implementation. The overall recommendation for the health care providers and the community in general was that intensified training and appropriate information was needed to cope with the technical and management skills for the PHC implementation. The establishment of a remuneration scheme for those working in difficult circumstances needed urgent attention in order to retain and motivate health workers.

3.2.1.3. The 1991 PHC Evaluation

According to the information received this evaluation was probably not carried out because at that time the District Household Survey For Monitoring Progress Towards Health For All by the Year 2000 (1990) was executed and provided the Government with the relevant information related to PHC implementation.

The survey of 27 indicators was a joint venture between WHO and the MOHCW to measure achievements towards the HFA strategy. Because of the data being collected of the rural areas it is representative for the PHC monitoring. After 1991 there were no PHC evaluations any more but replaced by HFA monitoring exercises. The survey on 27 health indicators was conducted on a sample of eight hundred households.

Analysis of the main indicators can be summarised as follows : on child survival status the survey suggested that 99% of the children under the age of five were developing without any physical, social or mental handicap. 93 % of all children in the age group 12-59 months had a child health card but the growth monitoring was not always done. Only 45.6% had growth monitoring data for the first twelve months of their lives. The maternal health and FP indicators were showing a positive picture with 59 % of the women using all the MCH/FP services. The youth health status and services indicators showed that most of them completed the primary education. The geriatric status and social services indicators revealed that 52 % of the 64 years and over were facing difficulties in walking or vision or had physical problems. The workers health indicators and services suggested that 80% of the 20-64 years age group were able to read and/or write and 8.2% of the working class indicated that health facilities were available at the workplace. The community and special health services indicators revealed that for water and sanitation 50% in the rural areas had access to safe drinking water but 55% had no access to toilet facilities. The accessibility of drugs was also assessed and most households indicated that the essential drugs were available within walking distance and 92% obtained the drugs from the government health facilities.

The analysis of the HFA strategy over time is a relevant monitoring tool for comparing trends in health status and services at all levels.

3.2.2. Community Based Surveys related to MCH/FP

The Zimbabwe Reproductive Health Survey was conducted in 1984 by the ZNFPC with the technical assistance of CSO. Using a sub-sample of the Zimbabwe National Household Survey Capability Programme master sample, 2 574 females aged 15-49 were interviewed in the survey. The survey was designed to collect data from the respondents on reproductive health behaviour and attitudes with respect to the knowledge and use of FP.

The PHC/MCH/ARI Survey was carried out in 1988 and the Maternal and Child Health and Family Planning (MCH/FP) Survey was conducted in 1991. The routine data from the National Health Information System (NHIS) was not reliable and consistent at that time to provide enough data on MCH/FP issues. Ideal this survey was proposed to be carried out every five year. A new survey is being planned for 1997. The indicators generated in the survey were the ones related to MCH/FP as the programme is the focus of PHC in Zimbabwe. The general objective of the coverage survey was to determine the extent of the coverage of MCH/FP indicators at National and Provincial level and major cities with the aim to generate information for planning and evaluation. The information generated served as a base line for the sixteen districts of the FHP, in order for them to implement their second phase.

The specific objectives were :

- to investigate if the country had achieved the Universal Child Immunisation (UCI) by evaluating coverage of each of the EPI vaccines among children 12-23 months
- to assess nutritional status of children 0-59 months
- to investigate the coverage of maternity indicators (deliveries by trained personnel, ANC, TT coverage, PNC) in looking at the women with babies in the twelve months preceding the survey
- to determine the level of knowledge and use of FP services
- to determine the accessibility of Health Services and Quality of Service

3.2.3. Central Statistical Office (CSO)

The Central Statistical Office is conducting on a regular basis population censuses, providing information related to mortality of the child and mother, literacy, water and sanitation, etc.

3.2.3.1. Census 1982

The 1982 Population census was the first large scale data collection exercise after independence in 1980. Prior to independence, census was taken as early as 1901 but this was confined to the non-African community. The 1982 census was conducted on a de facto basis. Individuals were enumerated where they happened to be at the time of the enumeration irrespective of their place of residence. The survey was conducted with a single reference period and the same questionnaire for the whole population. The reported population was therefore related to the 18th of August 1982.

The census report presented the analysis of the main demographic features of the population of Zimbabwe. It provided an assessment of the field enumeration, estimates of inter-censal growth rates and the geographic and urban-rural distribution of the population. It investigated briefly the past trends of population

growth, sex-age composition, the school enrolment, literacy, labour force including employment aspects. The report revealed some of the health related aspects such as life expectancy, fertility and mortality of mother and child.

The country had gone through several political, social and economic changes since the 1969 census and the need for a national census after independence was felt by the different development and planning sectors.

3.2.3.2. Census 1992

The 1992 Population Census is the second census that was undertaken by the Government of Zimbabwe since independence in 1980. It was carried out 10 years after the first census in 1982. The profile summarised the main findings of the 1992 population census with highlights at the provincial levels. In an effort to update and supplement data collection, one of the census objective was to provide current information on demographic and related socio-economic characteristics of the population at national and sub-national levels in order to facilitate effective planning and evaluation of development programmes. The data collected gave an appraisal of the past, an assessment of the present and an estimation of the future trends.

The 1992 census was conducted like the 1982 census on a de facto basis relating to the night of 17th of August 1992. The household and the individual were the main objects of the census within a geographical frame of provinces, administrative districts, wards (WADCO) and villages (VIDCO).

3.2.3.3. The Major Results of Both The 1982 and The 1992 Censuses

The 1992 census figures revealed that the population was 10.4 million with 5.1 million males and 5.3 million females meaning 95 males for every 100 females. This population constituted 2.2 million households with an average of five persons per household. The area was about 390 757 square kilometres which gave a density of 27 persons per square km. The 1982 census estimated the population at 7.6 million consisting of 3.7 and 3.9 million males and females respectively with a sex ratio of 97 males per 100 females. The 1982 population constituted of 1.6 million households with 5 persons per household. The density of population per square kilometre was 20 persons. The average population growth rate between 1982 and 1992 was 3.13 percent. The provincial growth rate between 1982 and 1992 could not be computed as the geographical areas of the provinces were not the same for the two periods. The migration pattern between the two censuses should be read with caution because of the boundary changes as documented in both censuses. The literacy rates of 1992 were for males 86 % and females 75 % which were higher than in 1982 with the literacy rate for males being 70 % and for females 56 %. As from 1982 to 1992 the trend in fertility was declining from 6.18 to 5.91 children per women although a little rise in the 1987 inter-censal report was mentioned using the indirect method of data collection. The same trends happened for the maternal and child mortality rates.

3.2.3.4. Demographic Health Survey 1988

The Central Statistical Office (CSO) conducted two surveys as part of the world-wide Demographic and Health Survey Programme. The first Zimbabwe Demographic Health Survey (ZDHS) was fielded in 1988 in order to present basic demographic and health parameters which were of interest to policy makers and health programme managers, researchers. The objectives of the 1988 were to collect detailed information on fertility levels, trends and preferences, family planning awareness, approval and use, basic indicators on maternal and child health including infant mortality and various other family health related topics. The MOHCW and the ZNFPC were involved in the planning as well as donor organisations and other government sectors. The 1988 ZDHS reported that Zimbabwe had high but stable fertility levels (5.5 children per women) which showed a decline which was more striking when women had secondary education (4 children per women). In 1988 the contraceptive knowledge was 96 % for all women with the pill the best known method. The use of any contraceptive method was about 43 % currently using and 36 % ever used a method for currently married women. The ZDHS also indicated that infant (53/1 000) and child (24/1 000) mortality levels were declining and that maternal education had serious impact on child survival. The health care mothers received during pregnancy and delivery was improving as for 91 % of births, the mothers received ANC, and about 70 % of births were attended by health personnel. The ZDHS reported also that the immunisation coverage was relatively good as 96 % of children 12-23 months received at least one immunisation and 86 % have been fully immunised according to the Child Health Card. The ZDHS of 1988 included information related to the then new public health problem, AIDS.

3.2.3.5. Demographic Health Survey 1994

The ZDHS of 1994 is the second survey in its kind which was been conducted by the CSO. The 1994 ZDHS collected information on fertility, fertility preferences, family planning, infant and child mortality and health related matters such as breast-feeding practices, ante-natal care, children's immunisations, childhood diseases, nutritional status of mothers and young children and awareness regarding STD, AIDS/HIV. The data collected was for use by programme managers and policy makers to evaluate and improve family planning and other health programmes in Zimbabwe. The survey showed a decline in fertility over the past decade with 4.3 children per women, which was a 22% decline from the 1988 ZDHS survey. The knowledge and use of FP methods had risen since the 1988 ZDHS survey. The use of a contraceptive method by currently married women was at the time of the survey 48 % and the use of modern methods increased from 36 % in the 1988 ZDHS to 42 % in the 1994 ZDHS. One of the main objective was to document the levels and trends in mortality among children under the age of five. The child survival prospects were not improved since the late eighties. Almost the same data were found in both surveys. The ZDHS estimated the maternal mortality rate at 283 deaths per 100 000 live births. This meant that a Zimbabwe women had a one in 59 chance of dying from maternal causes during her life time. The ZDHS of 1994

reported that 80 % of children of 12-23 months were fully immunised against the major childhood diseases. About 67 % received all the recommended vaccination before the first year of life. The results related to nutrition showed that although breast-feeding was commonly practised, with 99 % of the children being breast fed for some time, 21 % of children under three years of age were stunted and 6 % wasted. The survey reported on the AIDS related knowledge of the population. Although most men and women have heard about AIDS the quality of their knowledge was poor at the time of the survey.

4. HEALTH INFORMATION SYSTEM

The public health system in Zimbabwe has maintained since the 1950's a disease surveillance system built around the notifiable diseases under the public health act forming an important information base nation wide. A comprehensive and integrated health information system was initiated in 1986 and further strengthened in 1989 in developing a supportive system for planning, management of the health services at all levels. As of 1990 the system has been decentralised to the provinces with a provincial health information and medical record officer in place supported by the PMO. From 1992 onwards the system was further decentralised to the districts with the creation of district health information clerks at government and mission hospitals. Although the epidemiological capacity for surveillance and information has been developed at national and provincial levels, the district level remains still weak.

The mission statement of the health surveillance and health information unit in Zimbabwe is : to provide a relevant, reliable, complete and timely patient, disease, health status and health information base to clinicians, health policy makers, health planners, programme managers and supervisors at all levels of the health care delivery system. This development supports :

- quality patient management through a medical record system that is problem oriented
- health services and programme management in the provision of a data base from routine health information and the sentinel surveillance systems for situation analysis, policies and strategy development as well as supporting the health programmes through health surveys for base line information
- the early detection, epidemic preparedness and effective control programmes in the development of a disease surveillance system

The unit has a vertical component on policy, strategies and guidelines, case definitions, human resources development, resource mobilisation, training etc., with an integrated horizontal component on data analysis, reports, dissemination and utilisation of the information for health services and health programme planning including disease control. The National Health Information Unit developed a five year plan covering the period 1996-2000. It will be reviewed in the context of the Health Sector Reform Implementation. The emphasis of the five year plan is on the promotion of the effective use of high quality information for decision making at all levels. In view of the reforms, the emphasis will be put on linking 'resource utilisation' and 'manpower information' to the financial information.

4.1. FORMS

4.1.1. T5 form

This form is an integrated form for all health centres and hospitals. The data are collected on a monthly basis. The summary is sent to the health information system

in the EDC Department at Central Level. It is a summary of the T6, T3 tally sheets, the Master Card summary for children under five clinic, the Outpatient Department (OPD) Register, the Maternity Register. It is a collection of information related to :

- morbidity patterns of OPD general diseases or conditions, EPI target diseases, OPD chronic diseases or conditions that facilitate the calculation of the disease incidences, the effectiveness of the EPI programme and the identification of the Top 5 or 10 leading causes of diseases
- preventive health services such as :
    - * EPI Vaccinations (i.e. measles, whooping cough, diphtheria, poliomyelitis and tetanus) aiming at the provision of coverage of a target population by each specific vaccine, measuring the drop out rate, giving feed back on educational campaigns
    - * Tetanus Toxoid Vaccination aiming at the completion rate or drop out rate
    - * ANC and PNC Care aiming at monitoring coverage of first ante-natal visits versus the expected number of pregnant women and PNC visits versus the total deliveries in institutions or catchment area and assessing the quality of the ANC and PNC care programme
    - * FP aiming at the monitoring new clients, use and preferences of contraceptive methods
    - * Growth Monitoring summarising the weighing performed at the under five clinic on a monthly basis, monitoring the trends in low birth weight, and undernutrition
    - * Maternity containing information on number of deliveries, place of delivery, conditions of babies, maternal deaths. This information assist in the calculation of institutional delivery coverage, perinatal and maternal mortality

4.1.2. T9 Form

This form is also known as the 'in-patient' form for the admitted patients, and summarises information on T7 and T8 forms. The T9 Form has a list of most diseases or conditions classified in accordance with the International Classification of Diseases (ICD-10) Standard. It is the only return-form where detailed information on in-patients morbidity and mortality is available. Correct coding is very important for comparison with other hospitals, districts, provinces even other countries.

4.1.3. T1 Form

The T1 form is the form for notification of infectious diseases which are Anthrax, Cholera, Diphtheria, Hepatitis (all forms), Meningococcal Meningitis, Plague, Poliomyelitis, Rabies, Typhoid, Typhus, Viral Haemorrhaegic Fever, Yellow Fever.

The notification of these diseases and the close monitoring is necessary because of their way of spreading and control measures which need to be taken when there is an outbreak.

Tuberculosis (TB) and Leprosy are also notifiable but they continue to be reported on the TB Form A and the TB Form B and Leprosy is notified on the Leprosy Form.

4.1.4. T2 Form

T2 is a consolidated monthly return report on the notifiable diseases of Form T1 from all health institutions, responding to the Public Health Act. It contains all cases of notifiable diseases seen during the month. The information is then sent to Head Office via the district and the province.

4.1.5. HS3/5 System Form

This form captures the information on a monthly basis, collected from various input forms and registers already being used in different departments and service areas within the hospital. This information generates hospital based health indicators such as bed usage statistics, performance of health staff, cost of health service, e.g. cost per day-stay or per bed. The HS3/5 is the new revised form and substitutes the HS3, HS4, HS5. HS3 was previously representing the statistics, other than maternity, submitted by the Government hospitals. The HS4 was representing the statistics, other than maternity, submitted by Grant-aided Mission Hospitals. The HS5 was representing maternity statistics submitted by both Government and Grant-aided Mission Hospitals. The HS3/5 shows the statistics collected on thirteen different departments within a hospital setting. Every hospital, Government Hospitals (rural, district, general, provincial and central) and Mission Hospitals in the country are expected to complete the form, and following the route of submission to the next level in the health information system to the EDC Unit at the Central Level.

4.1.6. TB Reporting System

The TB reporting system is a specialised data collection system. The TB information is gathered from the hospital and send through to the next level in the health information system to the EDC Unit at central level. The patient with TB is registered at the health centre or hospital where he or she receives treatment. If admitted to the hospital for initial treatment, the patient will be registered as a new case in the diagnostic centre. Newly diagnosed patients are registered as new cases in the District Tuberculosis Register of their district. A complete TB folder is remaining at the treatment centre. The patient has a individual TB Treatment Card filled in at the start of the treatment at the diagnostic centre.

When patients are sputum smear positive after completion of a full category I treatment regimen they are notified by Form A as a re-treatment. Registration as a defaulter is done only after at least one month of defaulting.

As indicated before on admission for the intensive phase a complete TB Folder is filled which is a reference document for the treatment unit. At the same time three copies of the Notification A-Form are filled and the District TB Co-ordinator (DTC) enters the details of the patient in the Unit or the District Tuberculosis Register.

A specific form (TB contact tracing form) is used for contact tracing immediately after starting the treatment for the TB patient. Any person that was in close contact with the patient in the household or at work need to be traced. He has to be referred to the nearest health centre when complaining of specific symptoms related to TB. A register is then kept with names of contacts for follow up or evaluation. The Form is send to the DTC.

The Patient Card for Tuberculosis Treatment is filled during admission and functions as a passport during and after treatment and enables the continuation and follow up. If the patient is transferred to another centre Transfer Forms are filled.

The District TB Register is a compilation of all information gathered at review clinics, the information on treatment compliance and defaulting of patients under treatment at clinic level, the information on the entering of patients newly transferred from elsewhere, information on transfers out, information on laboratory results (smear positive PTB patients), information on treatment outcome. The cross checking of the T5 and the T9 data pertaining to TB (chronic disease table) is done in collaboration with the District Health Information Clerk.

In the past epidemiology of TB in Zimbabwe focused mainly on case finding and registration. Outcome analysis is an important indicator of the efficiency and the effectiveness of the control programme.

The DMO is responsible for the initial interpretation of all data compiled by the DTC at district level. The DTC submits a summary sheet with all notifications stratified for sputum status, sex, age, and type of patient on a monthly basis. Quarterly review of treatment outcome and programme results are reported per district using a cohort analysis format (quarterly report on the results of TB patients registered 12-15 months earlier) which is done in close collaboration with the province or city.

The provincial TB and Leprosy co-ordinator works in close collaboration with the MOHCW EDC Unit and the provincial environmental health officer (PEHO). The team is responsible for the programme management at provincial level. The compilation of the data extracted from the district registers in the provincial database gives an overview of performance of the programme in the province or city. Feedback to the national level on results of case finding takes place on a monthly basis. The reporting of treatment outcome evaluation (cohort analysis) to national level is taking place on a quarterly basis.

At the national level the national TB data base is maintained and fed with the monthly and quarterly reports from the provinces and cities. Projections of future drug needs are done on the basis of the analysis of the national database in order to facilitate the buffer stock management.

4.1.7. AIDS Reporting System

Surveillance activities on HIV/AIDS became operational in 1989 based on passive routine AIDS cases and deaths reporting system. In 1990 sentinel sero-surveillance activities were conducted in 16 sites throughout the country.

National notification of HIV/AIDS is less valuable for epidemiological monitoring than well implemented surveillance of HIV/AIDS among sentinel groups and consistent case reporting. The AIDS reporting system is a separate reporting system which includes the reporting from the sentinel sites on HIV prevalence among high risk groups to monitor the trends of the infection. Following the National Workshop on HIV surveillance in Nyanga, 1997 and the Multi-sectoral review and Planning Workshop in Kadoma, 1997 the provinces and cities were requested to establish or confirm the HIV sentinel sites. The basic areas of HIV/AIDS surveillance in the country are :

- routine surveillance of out-patients and in-patients clinic or hospital based
- laboratory and blood donor service surveillance
- special risk groups sero-prevalence surveillance, HIV-sentinel site surveillance, women at ANC clinics, students between 15 and 19 years
- information from community associations, NGOs, Churches, home based care suppliers, survey and research

The routine surveillance for HIV related disease and AIDS in adults and children based on a simplified case definition (clinical symptoms and signs only) will be discussed by the national committee of the NACP.

In relation to the routine surveillance, the patient card is filled in with the positive or negative results of the HIV test done including the Laboratory code number which is recorded using the ICD-9 code numbers for confidentiality awaiting the ICD-10 codes to come out. The OPD new cases and the follow up will be reported on a monthly basis through the present T5 Forms. The female condoms which will be issued from June 1997 onwards, will be tallied in the T5 section Family Planning under other methods and reported on the monthly return. All aggregated information, analysis and dissemination of HIV and AIDS data from the district, provinces and cities including head office will have supplemented information on TB cases, STD cases, male and female condoms, the incidence rate of TB for 100 000 population and the incidence rate of STI for 1 000 population (adults only but including the 15 years old and more). The rapid surveillance WS will include a section on a monthly basis related to HIV and the related diseases or conditions.

For the in-patients admissions reporting system, the patients that are discharged alive or dead with the diagnosis of HIV related diseases and AIDS will receive a coded diagnosis, recorded on the patients medical notes. The health information clerk or officer in charge at each hospital will report the codes in the T9 Form and in case of death a copy of the death certificate will be attached.

The results of the Public Health Laboratory will be submitted regularly and timely to the EDC-NHIS Unit at the end of each calendar month and the nearest health authority. The results will be tabulated at various levels and the EDC-NHIS Unit will disseminate them on a monthly basis as an annex to the WS report with a feed back to all reporting HIV Labs. The Public Health Laboratory in collaboration with the clinic staff will record the results of each HIV test performed with a Laboratory code number on the patient card to avoid duplication in testing.

4.2. PUBLICATIONS BY THE MOHCW EDC-NHIS UNIT

- Weekly Surveillance Report
- Quarterly Health Statistics Report
- The Annual Health Statistics Report (Annual)
- Health Facilities Report (Annual)
- Maternal Mortality Report (Annual)
- Vital Statistics Report (Annual)
- Health Profile (Annual)

5. CO-OPERATION WITH INTERNATIONAL ORGANISATIONS/ INSTITUTIONS

5.1. THE WORLD HEALTH ORGANISATION (WHO)

The WHO based in Zimbabwe has a dual role in implementing its health related activities and is structured as follows :

- The WHO Country Programmes in Zimbabwe
- The WHO Inter-Country Support Team Based in Zimbabwe for the Inter-Country Projects
- The Management Support (MPN) programme consisting of a Administrative Support, Finance Support , Secretarial Support, Library and Exhibition, Support Staff and Drivers Pool, is the overall support to the Country Programmes and the Inter-Country Projects of the WHO in Harare

During the past 17 years the WHO was actively participating in the process of providing technical, financial, and information support to the Zimbabwe health sector. The WHOs support intensified after 1985 when the Health Ministry adopted the Africa Health Development framework and started to implement it.

In its collaboration with the MOHCW and the other agencies positive results were produced in the areas such as :

- Development of PHC services at the national, provincial and district levels through training in district health services management, programme monitoring and periodic PHC reviews
- Technical support to the National AIDS Control Programme in the development of disease surveillance, counselling, information, education and communication including programme management for HIV/AIDS prevention and control
- Development of strategies for the following Communicable Disease Control programmes : ARI, CDD including Cholera, Leprosy, Malaria and TB control. Through EPI the following diseases are being prevented or controlled : Diphtheria, Measles, Poliomyelitis, Tetanus, Whooping Cough and TB
- Technical assistance to the MCH/FP and Safe Motherhood Services
- Development of Community Initiatives in Health through community mobilisation by strengthening the capacity of the national health system
- Promotion of Health System Research initiatives at the national, provincial and district levels through training of health and social science personnel
- Provision of technical assistance in the development of Health Care Financing Strategies
- Development of national Safe Water and Sanitation Programmes
- Establishment of Quality Assurance Procedures and an Efficient Essential Drug Programme

Presently the technical co-operation between the MOHCW and the WHO enters a new phase where priorities are focused on Health Sector Reform, Cost Effectiveness and Rationalisation.

5.1.1. History of Co-operation and Organisation

5.1.1.1. The WHO Country Team (WCT) in Zimbabwe

The WHO Office was established at Independence in 1980. During that period WHO was and is still a principal partner in the provision of technical, financial and information support to the Zimbabwe Health Sector. A further development was the setting up of the WHO Country Team in 1990. This multi-disciplinary WHO Country Team is addressing the Primary Health Care implementation in the country but has also the responsibility to strengthen the national capacity to respond urgently to Health Emergencies and accelerate the Health Development.

The team headed by the WHO Representative (WR)/Team Leader, includes national and international staff for :

- the Information, Education for Health (IEH) Programme
- the MCH/FP or Women and Child Programme
- the HIV/AIDS Programme
- the Community Water supply and Sanitation Programme (CWS)
- the Emergency Preparedness and Response Programme (EPR)
- the Disease Prevention and Control Programme (DPC)
- the Primary Health Care Programme
- the Human Resources for Health (HRH)
- General Programme Development and Health Economics (GPD)
- Nursing Programme
- Drugs and Vaccine Availability (DSE) Programme
- Health Situation Trends (HST) Programme

Most of the country team members are based at the MOHCW Headquarters Office.

5.1.1.2. The WHO Inter-Country Support Team Based in Zimbabwe

This team consists of officers providing technical support to countries in Southern Africa, including Zimbabwe. The main areas of support include :

- Health System Research
- Child Immunisation and Polio Eradication
- Women Health and Development
- Diarrhoeal Disease Control (CDD)
- Emergency Preparedness and Response (EPR)

5.1.2. Organisational Chart

The organisational structure of WHO Zimbabwe is drafted in Figure 33.

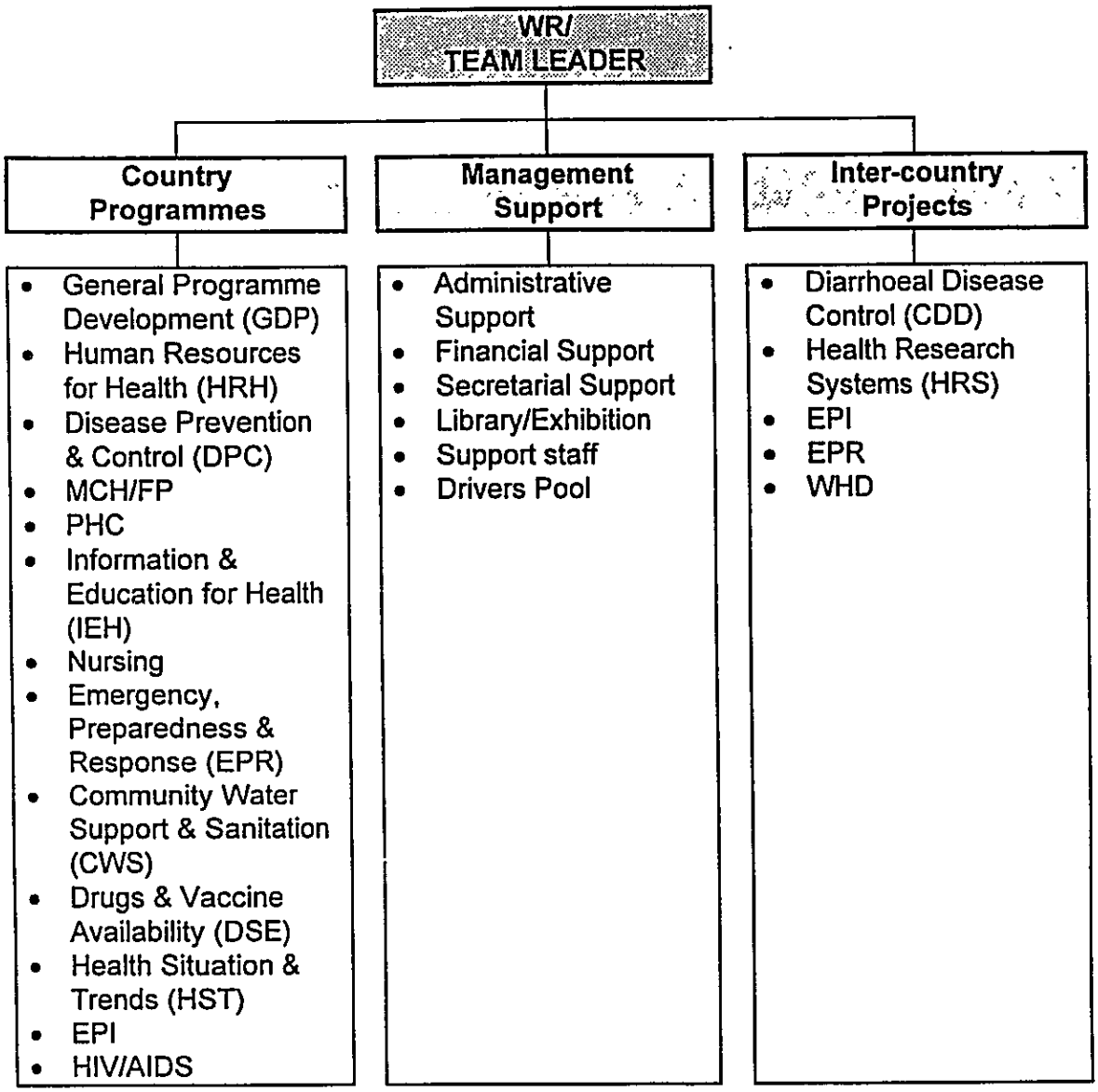

FIGURE 33 : ORGANISATIONAL STRUCTURE OF WHO ZIMBABWE

5.1.3. Policy, Priority and Plan of Co-operation for WHO with Zimbabwe

The policy of WHO in general is the supportive commitment to the government's general objective in the health sector in line and conform to the WHO policies of Primary Health Care, Communicable Disease Control including AIDS, Maternal and Child Health and Environmental Health. WHO's support during the FY 1997 will focus on the Governments' implementation of the policy of equity in health as a

means of achieving the goal of HFA by the Year 2000. Programmes and activities to achieve this goal are summarised in the MOHCW health reform initiatives. The components such as decentralisation of services, community based health care programmes, improved financial planning and accountability, training and capacity building, disease prevention and control and improved community based health care delivery are focused on in WHO support programmes and initiatives. Support will also be provided by WHO to water and sanitation as well as emergency preparedness and response programmes.

The plan of work will cover nine programme areas through the WHO Regular Budget and two Programme areas for extra budgetary support (EPR and CDD).

5.1.4. Country Priorities

5.1.4.1. Human Resources for Health

Biennial Objectives :

- to ensure specialist training for 31 health personnel and ensure participation of 20 health personnel in priority meetings and workshops
- To publish 8 issues in the Publication of the National Digest, Current Health Information Zimbabwe (CHIZ)
- to meet the basic needs of the UZ Medical School for journalism
- to award three research grants

Resources : US $ 185 000

5.1.4.2. Health Situation and Trends

Biennial Objective :

- to ensure that by the end of 1997, two districts in each of the 8 provinces had established a district data base, prepared a district profile and set up a data presentation board.

Note : the Biennial Budget was used totally in 1996 which was US $ 10 000.

5.1.4.3. Integrated Control of Diseases

Biennial Objectives :

- to strengthen by 1997 the Epidemiology Department with human resources and with increased capacity to provide technical and logistic support for epidemic preparedness and control

- increase the coverage to 40 districts from the 60 with training in Epidemiology control

Resources : US $ 140 000

5.1.4.4. AIDS

Biennial Objective :

- to increase by the end of 1997 the awareness and the motivation of youth and women to adopt appropriate behaviour in all provinces.

Note : The biennial funds of US $ 50 000 were completely used in 1996.

5.1.4.5. Primary Health Care

Biennial Objectives :

- to create an operational organisation at the MOHCW
- to develop new planning guidelines
- to train 300 health workers
- to conduct the best district, provincial and central hospital competitions
- to introduce new community health development projects in 2 provinces

Resources : US $ 150 000

5.1.4.6. Women and Child Health

Biennial Objectives :

- to train senior RHC nurses, midwives and VHW co-ordinators from all provinces in referral management of pregnant women with high risk factors
- to increase the ANC attendance to 95 %
- to provide or seek funds for provincial and district surveys
- to implement women's development programmes in 4 districts

Resources : US $ 178 000

5.1.4.7. Health Education and Information

Biennial Objective :

- to initiate the development of a School Health Policy and competitions
- to establish patient education programmes at all provinces and central hospitals
- to complete two health education officers post graduate training courses
- to introduce SCOP in all provinces

Resources : US $ 45 000

5.1.4.8. Community Water Supply and Sanitation

Biennial Objectives :

- to introduce RHC water improvements
- to provide training for Environmental Health Officers and Technicians
- to promote rural community health competitions
- to expand the Africa 2000 project

Resources : US $ 75 000

5.1.4.9. General Programme Development

Biennial Objectives :

- to field test the decentralisation of district health services to RHC in at least one province
- to reorganise the major functions in HQ, provincial offices to meet the new workload requirements of the MOHCW
- to develop HECAFIP initiatives to improve the financial controls

Resources : US $ 20 000

5.1.4.10. Technical Co-operation with Countries

Biennial Objectives :

- to improve technical, administrative and logistic support to WHO technical co-operation programme
- to improve information, reporting, financial management and monitoring of all regular and extra-budgetary funds

- to mobilise resources
- to become the Best WR of the year

Resources : US $ 320 000

5.1.5. Total Budget

The total biennial regular budget (1996-97) was US $ 2 388 000. An estimated balance of US $ 1 083 000 or 45.4% of the biennial budget was carried forward into the year 1997 as presented in Table 27. Figure 34 presents the WHO country support for the period 1982-97 with a projection for 1998/99.

TABLE 27 : TOTAL BIENNIAL BUDGET FOR 1996-97 ACCORDING TO PRIORITIES

Priority	Programme	Biennial Budget	Estimated Balance for 1997	Percentage 1997
Priority 1	Human Resources for Health	450 000	185 000	14.3%
Priority 2	Health Situation and Trend	10 000	-	0
Priority 3	Integrated Control of Diseases	310 000	140 000	12.9%
Priority 4	AIDS - funds from PR3.	50 000	-	0
Priority 5	Primary Health Care	300 000	150 000	13.9%
Priority 6	Women and Child Health	368 000	178 000	16.4%
Priority 7	Health Education and Information	80 000	45 000	4.2%
Priority 8	Community Water Supply and Sanitation	150 000	75 000	6.9%
Priority 9	General Programme Development	50 000	20 000	1.8%
Priority 10	Technical Co-operation with Countries - WR Office	670 000	320 000	29.6%
TOTAL		2 388 000	1 083 000	100%

Note : PR 2 and 4 were biennial budget items fully completed during 1996

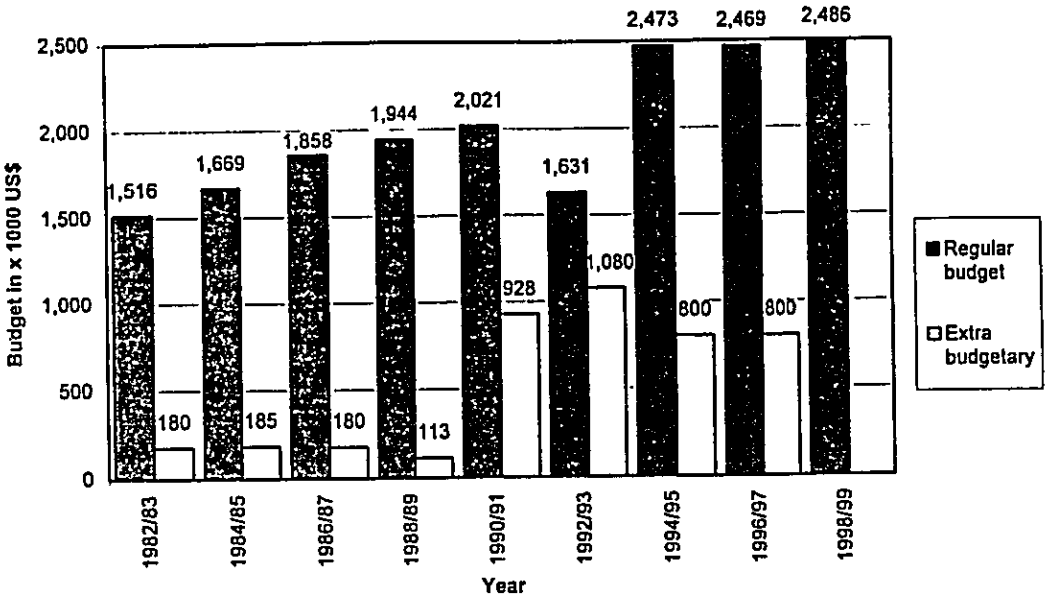

FIGURE 34 : WHO COUNTRY SUPPORT TO ZIMBABWE 1982/83 - 1998/99

5.2. THE UNITED NATIONS CHILDREN'S FUND (UNICEF)

5.2.1. History of Co-operation and organisation.

The basic agreement between the Government of Zimbabwe and UNICEF was concluded in 1981 and provided the basis for the relationship between the Government and UNICEF until it is changed by a new Basic Agreement presently under negotiation. UNICEF assistance to Zimbabwe fell by almost 50% over the period 1981 to 1991, reflecting satisfaction with the rate of progress made in relation to other countries in the region. But UNICEF realised that its support in Zimbabwe need to expand again as Zimbabwe tries to cope with the drought periods, socio-economic adjustments, and AIDS.

UNICEF plays a key role in support to the Government's efforts for more decentralisation and cost-effective strategies. UNICEF facilitates the sharing of experiences in the countries of the region which are facing similar problems. The current UNICEF programme for 1996-2000 amounts to US $ 8.4 million of its General Resources (GR) and US $ 42 million of Supplementary Funding (SF) of which some need still be sourced. UNICEF's programmes are building on the new positive trends of decentralisation and capacity building of local community structures developing in Zimbabwe.

5.2.2. Organisational Chart

The organisational structure is presented in Figure 35.

5.2.3. Policy, Priority and Plan of Co-operation for UNICEF with Zimbabwe 1995- 2000

The Country Programme runs from 1995-2000 which is the period covered by Zimbabwe's National Plan Of Action for Children (NPA). The NPA covers an enormous range of activities and involves hundreds of groups and organisations with an annual expenditure of US $ 500 - 1 000 million. UNICEF plays a small but critical role in this framework especially in protecting the social sector and in developing sustainable ways of social services delivery, empowerment of the communities to plan, manage and finance their own services. The major goal of the country programme is to assist the Government to develop strategies and mobilise resources to achieve the goals for children and women set out in the NPA within context of ESAP. The UNICEF Country Programme divided the goals in those achievable before the Dakar Consensus Goals, 1995 and those which were not feasible until later in the programme implementation. Table 28 summarises the feasibility analysis and the NPA goals. The new programme structure, including the new programme areas, is summarised in Figure 36.

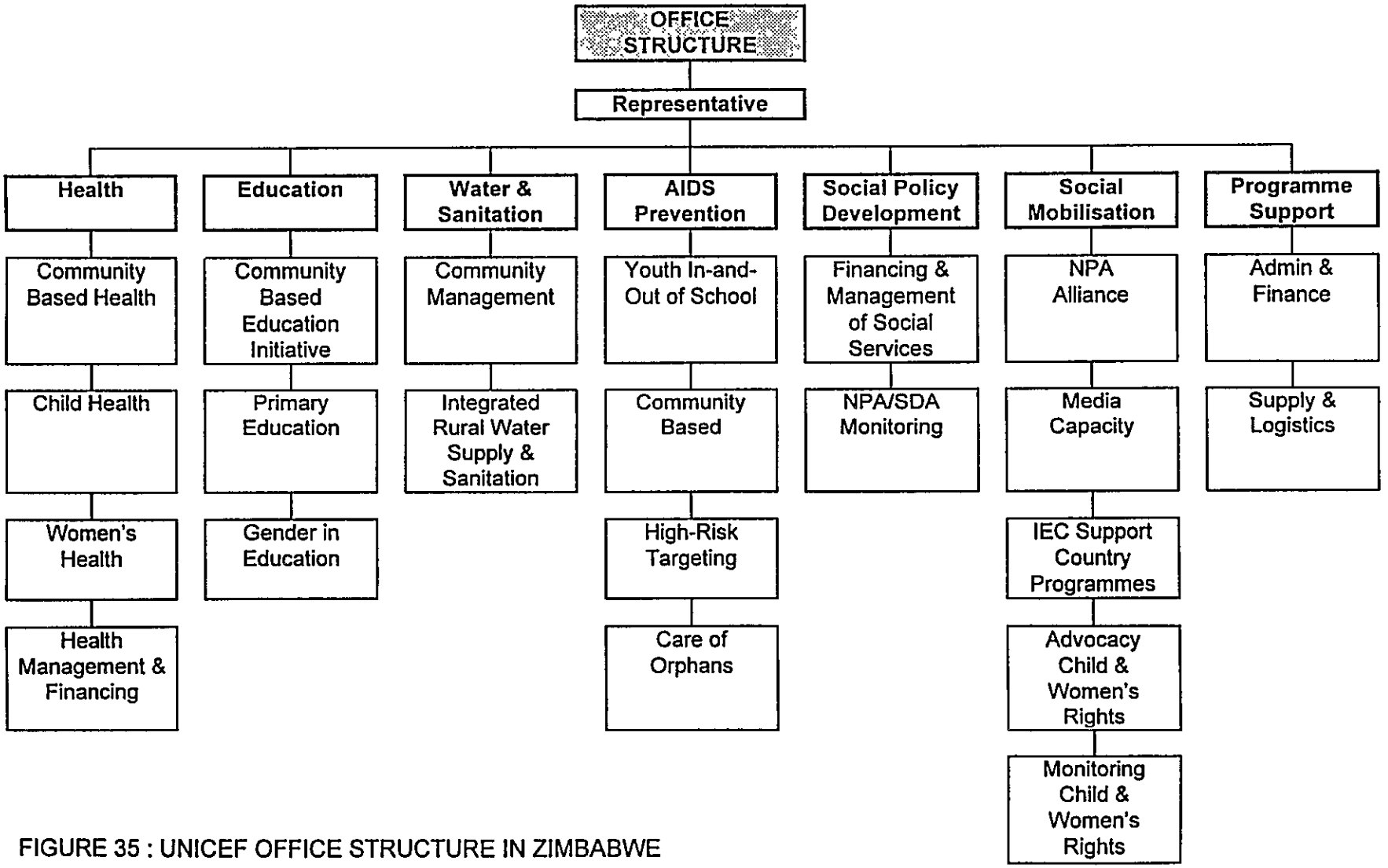

FIGURE 35 : UNICEF OFFICE STRUCTURE IN ZIMBABWE

TABLE 28 : FEASIBILITY ANALYSIS OF DAKAR CONSENSUS AND ZIMBABWE NPA GOALS

1. DAKAR CONSENSUS GOALS

Goal	Status as at 1992	Target Date	UNICEF Programme Support
DTP - 80% Polio - 80% BCG - 80%	71% 71% 71%	1994 1994 1994	Child Health Project (EPI)
Measles 90 % TT2 90%	70% 63%	1994 1995	Child Health Project (EPI)
ORT usage 80%	70%	1995	Child Health Project (CDD)
IDD elimination	Total Goitre Rate 44% Visible Goitre Rate 4%	1994	Child Health Project (Nutrition)
Vitamin A deficiency elimination	Not yet shown to be a problem in Zimbabwe	1993	Child Health Project (Nutrition)
Encourage exclusive breastfeeding 0-4/6 months	54 % breastmilk or breastmilk and water	1995	Child Health Project, Social Mobilisation Programme
Reduce girls' primary school drop-out rate by 30%	28% drop-out from primary school between grades 1 and 7	1995	Gender Equity in Education Project

2. MAJOR GOALS OF THE ZIMBABWE NPA FOR THE YEAR 2000

Goal	Present Status	UNICEF PROJECT SUPPORT
Reduce IMR to 40/1000 and U5MR to 58/1000	IMR 61/1000 U5MR 87/1000	All Projects in the Country Programme
Reduce maternal mortality to 40/1000	80/1000 (Institutional MMR)	The Women's Health Project, the Health Financing and Management Project, the AIDS prevention Programme, Women's Right Project, and the Social Policy Development Programme
Reduce severe and moderate malnutrition to 6% of 0-5 years olds with less than 75% standard weight for age	12% less than 75 weight for age	The Child Health Project (Nutrition) and the Community Based Education Initiatives Project
• Ensure universal access to safe drinking water • Ensure 50% access to safe excreta disposal	75% 21%	The Community based Water and Sanitation Project, the Integrated Water Supply and Sanitation Project and the Community Based Health Project
• 100% access to primary education • 48% access to Early Child Education (ECEC) • 100% completion of primary school	• 100% access to primary school • 20% ECEC access • 72% completion of primary school	The Education Programme and the Social Policy Development Programme
Reduce adult illiteracy level to 20%	38%	The Community Based Education Initiatives Project and the high levels of primary education
Ensure improved protection of children in special circumstances	68 000 orphans	The Social Policy Development Programme, the Community Based Care for Orphans Project, the Advocacy Programme

Source : The GOZ and UNICEF Programme of Co-operation 1995-2000

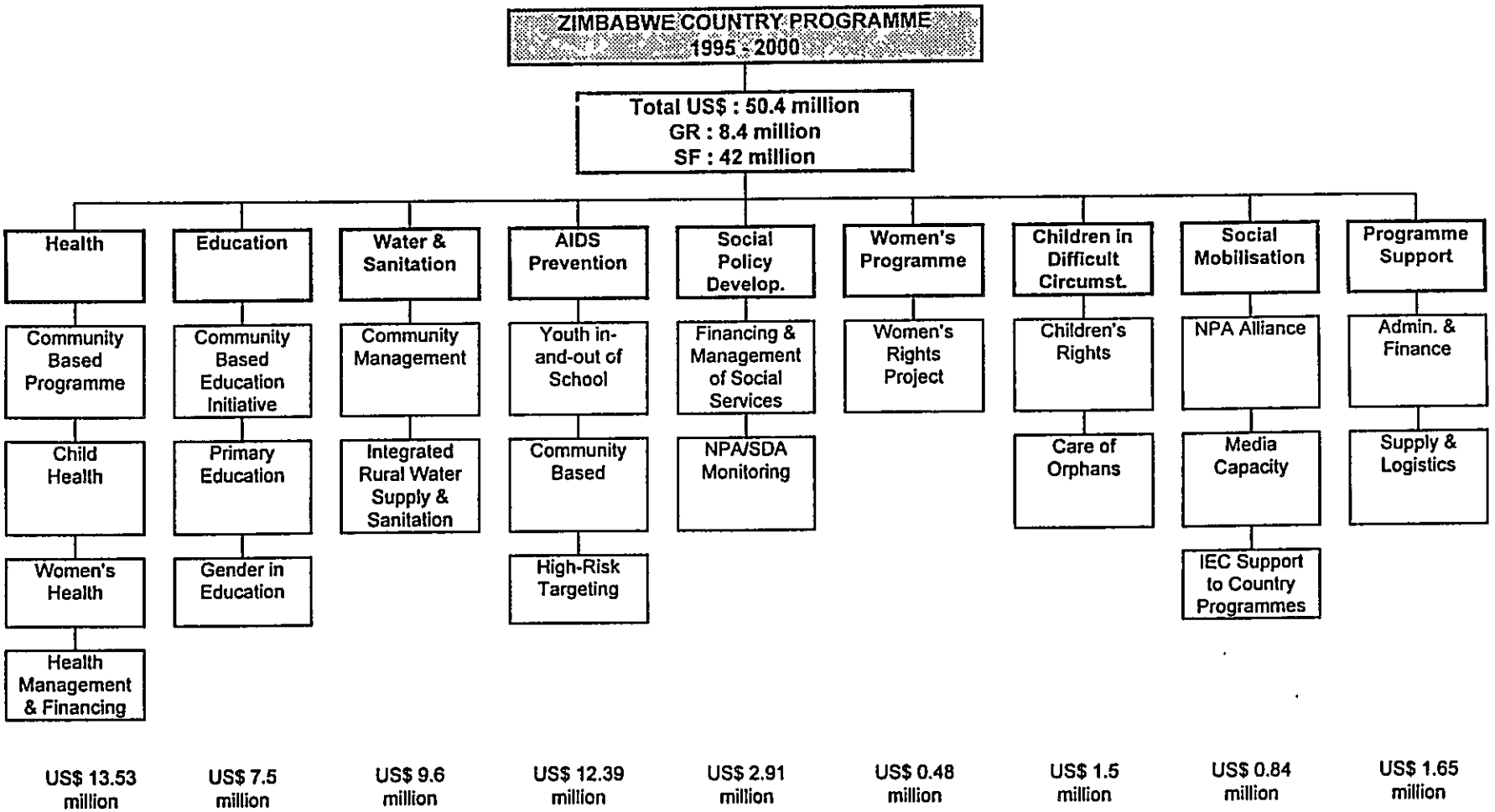

FIGURE 36: ZIMBABWE COUNTRY PROGRAMME 1995-2000 WITH BUDGET IN MILLION US$

5.2.4. UNICEF Country Programme Strategy

The overall strategy of the Programme contains elements of service delivery, capacity building and empowerment. The emphasis is on capacity building or capacity refinement to deliver more cost-effective sustainable methods of social service delivery.

The programme is also emphasising community level empowerment especially of women. UNICEF will continue to provide some key inputs to on-going programmes like polio vaccines and cold chain equipment.

The design of the new Country Programme reflects major changes including the social sector adjustment to ESAP, the emerging AIDS epidemic, the drought preparedness need, and the NPA. The approval of two new projects AIDS Prevention, Under Five Mortality Reduction are strategies that UNICEF applied to meet the country needs. A further change in the Country Programme Strategy is the moving away from service delivery and focusing on national capacity building and empowerment. A strategy focused on strengthening national capacity in assisting national institutions to improve social policy is also required.

5.2.5. Total Budget

Table 29 presents the UNICEF Country Support for the plan of co-operation 1995 - 2000.

TABLE 29 : SUMMARY OF BUDGET FOR 1995 - 2000

Programme	US $ x1000 GC	US $ x1000 SF	US $ x1000 Total
1. Social Policy Development	1 110	1 800	2 910
2. AIDS Programme	390	12 000	12 390
3. Children in special circumstances	300	900	1 200
4. Water and Sanitation	600	9 000	9 600
5. Health	1 530	12 000	13 530
6. Education	1 500	6 000	7 500
7. Women	480	0	480
8. Social Mobilisation	840	300	1 140
9. Programme Support	1 650	0	1 650
TOTAL	8 400	42 000	50 400

Source : The GOZ and UNICEF Programme of Co-operation 1995-2000

5.3. THE UNITED NATIONS POPULATION FUND (UNFPA)

5.3.1. History of Co-operation

The UNFPA support in Zimbabwe started in 1981, with the first post-independence national census (1982). The support to the MOHCW, excluding the ZNFPC, was only initiated in 1988 and the funding to the Ministry started in 1991/92. UNFPA support has always be more towards the ZNFPC which started in 1982/83. After the first post independence national census a first Zimbabwe Country Programme 1983-88 was supported with US $ 2.35 million. The second Country programme 1989-1993 was developed based on a first evaluation of the 1983-88 programme. The programme was supported with US $ 10 million. This programme was extended for two years to 1995 based on a mid-term review (MTR).

UNFPA's Second Country Programme was designed to support Zimbabwe's First and Second Five Year Development Plan as both periods were overlapping. UNFPA Country Programme 1996-1999 was designed after the review of the second country programme and is currently being implemented.

5.3.2. Organisational Structure with the Government

Figure 37 illustrates the relationship between UNFPA and the MOHCW/ZNFPC.

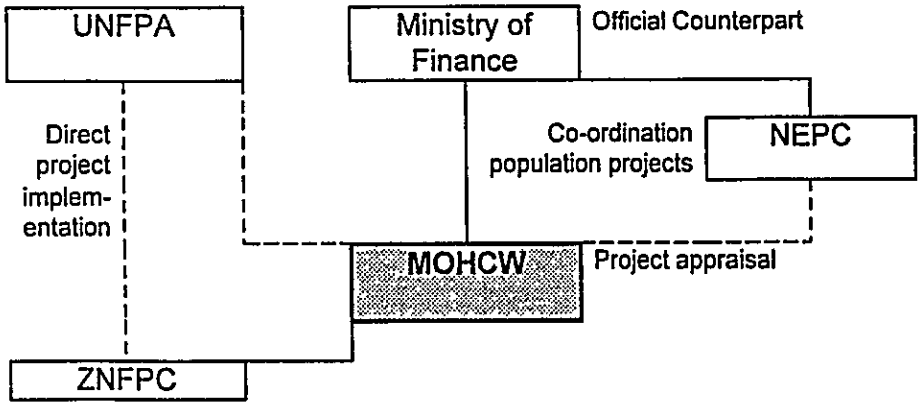

FIGURE 37 : OFFICIAL RELATIONS BETWEEN UNFPA & GOVERNMENT

5.3.3. Policy, Priorities, Strategies and Plan of Co-operation 1996-1999

Zimbabwe has made achievements in relation to population activities. A set of objectives and strategies to achieve the objectives are taken up in the third Country Programme 1996-1999. The areas of concern are Population Policy, Reproductive Health and Gender, Population and Development.

5.3.3.1. Policy

The overall policy of UNFPA is the commitment to the improvement in the quality of life of all Zimbabwean population through the achievement of sustainable socio-economic and human development.

5.3.3.2. Objectives and Strategies in order of Priority

5.3.3.2.a. *Related to Population Policy*

General Objective :

- to have population integrated in development planning

Specific Objectives :

- to have a National Population Policy formulated and ready for adoption by 1998.
- to establish and strengthen institutional structures for Integrated Population and Development Planning.

With strategies formulated as :

- improvement and expansion of data and knowledge base on the interrelationship between population and development, gender and population development in order to formulate the National Population Policy
- increasing awareness and acceptance on population issues for individual and family and increasing sustainable national development
- public debates on population and development issues for the building of consensus on the National Population Policy
- promotion of Gender sensitivity
- establishment and strengthening of Institutional Structures for Integrated Population and Development Planning
- Inter sectoral collaboration on policy and development issues
- initiation of the process on integrating population factors in development planning at all levels
- training in needs analysis, concepts, methodologies for the integration on population in development planning
- providing guidelines on development planning

5.3.3.2.b. *Related to Reproductive Health*

General Objective :

- to improve the reproductive health status of the Zimbabweans at all stages in the life-cycle, and ensure access to appropriate, affordable and quality health care

Specific Objectives :

- to reduce the incidence of induced abortion and its complications contributing to high maternal mortality and morbidity
- to promote adolescent reproductive health in reducing adolescent pregnancies to 10% by the year 2000 and prevention of HIV/AIDS and STI among them
- to reduce the MMR to about 200 per 100 000 live births by the year 2000, reducing the maternal morbidity
- to support the efforts of NACP and NGOs in the control of HIV/AIDS, emphasising the Girl child
- to reduce the incidence of the reproductive system cancers with emphasis on cervix cancer
- to expand knowledge and data base on Reproductive Health (RH) issues
- to reduce the levels of malnutrition among five years old from 12% to 6% by 2000
- to reduce malnutrition among schoolchildren and women of childbearing age
- to design RH programmes targeting the under-served groups, elderly and the people with disabilities
- to reduce child abuse and violence against women and children

Some of the major strategies are formulated as :

- Integration of prevention and management of induced abortion in a comprehensive RH care package and plan and provide continuous training and counselling services at all levels of health care
- involve women groups and NGOs in advocacy activities in order to reduce unsafe abortion and lobby for attitude change in order to improve treatment of women that had induced abortion
- provision of comprehensive RH services to adolescents and lobby for understanding and attitude change towards adolescent RH and service provision as well as relaxation of legal restrictions
- inclusion of adolescent health and sexuality in school curricula, and involve the youth in the design, implementation and monitoring of programmes targeted at improved RH and sexuality

- strengthening of the referral in the health care delivery system, increase the accessibility of maternity services to all pregnant women with an increased midwives deployment of 60% to the rural areas, and increased ANC quality by service providers
- development of policy and guidelines on Waiting Mother Shelters and strengthen Traditional Midwives training and management skills
- increasing the training capacity in screening and management of STIs, increase IEC in all aspects of STIs and AIDS/HIV and increase programme expertise and resources for routine care but targeting high risk groups
- increasing the condom utilisation from 16% to 25% by the year 2000 and increase access to quality FP
- strengthen cancer control programme and provide education related to cancers of the reproductive system, RH care for the elderly and the people with disabilities
- increasing the provision of FP services by the private sector and NGOs, and widen contraceptive mix, reduce the medical barriers to FP services
- provide information on availability, type, services and methods of FP and expand male motivation
- promote RH research and establish RH research centres for research on all aspects related to the reproductive health issues
- promotion of exclusive breast feeding, expand growth monitoring initiatives, consolidate Baby-Friendly Hospital Initiatives
- strengthen supplementary feeding schemes in schools, standardise school health programmes
- Improve the skills of health providers in early screening of pregnant women, in ANC and PNC services
- provide appropriate designed IEC programmes, services, facilities, and equipment at all levels of the health care delivery system with focus on the under-served groups
- awareness campaigns, advocacy and user-friendly institutions to be able to accommodate the consequences of violence and abuse against women and children

5.3.3.2.c. *Related to Gender, Population and Development*

General Objective :

- to ensure gender sensitive development that reduces the marginalisation of women and promotes gender equity including the empowerment of all women in Zimbabwe

Specific objectives :

- to reduce cultural, social and legal barriers to integration of women into development

- to maintain gender concerns in national and sectoral policies, plans, programmes
- to ensure greater participation of women in the economy
- to reduce violence against women and make the consequences visible to the general public

Some of the strategies are formulated as :

- increasing awareness among women of issues that promote gender equity
- conducting research related to gender issues, barriers, legal aspects and access and availability to services related to gender issues
- strengthen affirmative action for women in sectoral policies for better participation of women in decision making positions in government and private sectors
- advocacy for gender policy, strengthen the skills of women leaders in advocacy
- ensure the basic education of the girl child and eliminate the drop out of female students in schools, promote female and functional literacy education for females
- support income generating activities for poverty alleviation among women

5.3.4. Total Budget 1996-1999 in US $

Table 30 presents the total budget of UNFPA's support to country programmes.

TABLE 30 : TOTAL BUDGET IN US$ FOR 1996-99

	Regular Funds	Other	Total
Reproductive Health	4 500 000	2 400 000*	6 900 000
Population and Development Strategies	1 100 000	100 000+	1 200 000
Advocacy	800 000	-	800 000
TOTAL	6 400 000	2 500 000	8 900 000

*: of which 1 600 000 has been secured from CIDA and DANIDA, resources need to be found for balance of 900 000

+ : secured from ADAB

The payments for the MOHCW follow a direct route, for the ZNFPC projects the budget flows through the national executive body.

5.4. JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS)

5.4.1. History of Co-operation

The United Nations AIDS Programme was previously let by WHO under the Global Programme on AIDS (GPA) which was dismantled in 1995. GPA worked very closely with the MOHCW. GPA assisted the MOHCW to set up the NACP through the provision of both monitoring and technical support. The role of GPA was taken over by a joint and co-sponsored UN programme. The programme is financed by WHO, UNICEF, UNDP, UNFPA, UNESCO and the World Bank. The partnership and co-sponsorship is known as UNAIDS. UNAIDS is the summary of activities of the co-sponsorship. The programme works closely together with the MOHCW since 1996 after the GPA period under the chairmanship of WHO.

5.4.2. Organisation and Structure

The UNAIDS programme is not an organisation but an arrangement for co-ordinating the inputs of all participating UN agencies to the National Response. UNAIDS in Zimbabwe works through the interaction of the UN Steering Committee on HIV/AIDS (Committee of Heads of WHO, UNICEF, UNDP, UNFPA, UNESCO and the WB) and the UNAIDS Programme Development Committee (Committee of HIV/AIDS focal persons from WHO, UNICEF, UNDP, UNFPA, UNESCO, WB). The technical support is provided by the office of the Country Programme Advisor (CPA).

Figure 38 presents the inter-relationship of the UNAIDS Partnership Programme.

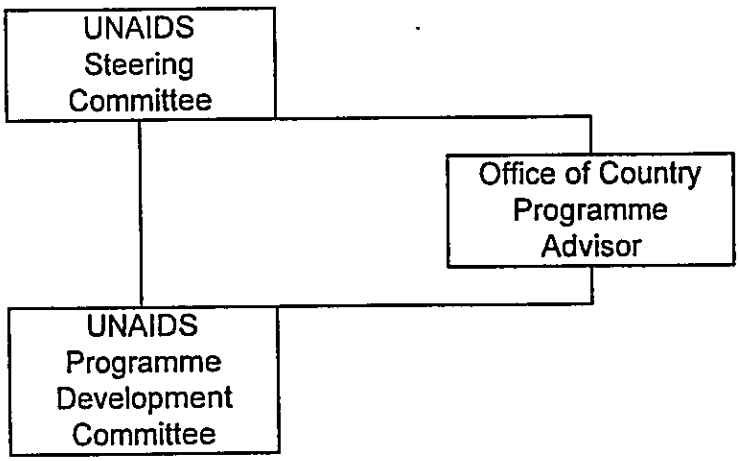

FIGURE 38 : INTERNAL CHANNELS OF THE STRUCTURE

5.4.3. Policy, Priorities, Plan of Co-operation for UNAIDS and Programmes

UNAIDS is not a funding agency and its support is in its work through the National AIDS Co-ordination Programme (NACP). The HIV/AIDS Thematic group or UNAIDS is committed to support the policy and objectives of the National AIDS programme. The priorities of the Programme are :

- to mobilise resources for the financial and technical support to AIDS and AIDS related programmes
- to support the planning and co-ordination process of the NACP
- to increase advocacy for an expanded response
- to support the reproductive health programme in the procurement and distribution of female condoms
- to assist in the primary health care development and the home based care programme
- to assist in the Epidemiology development
- to support the Governments efforts to expand the National Response
- to identify and support the application of best practice
- to promote and assist the health education and information related to AIDS/HIV and STI
- to monitor and evaluate the activities

5.4.4. Total Budget

The budget for 1996 was about US $ 1.08 million.
For 1997 US$ 788 000 but more funding is provided from the individual co-sponsors directly to NACP.

5.5. UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)

5.5.1. History of co-operation and organisation

UNDP is not directly collaborating with the MOHCW but UNDP has provided in the past US $ 1 million between 1989 and 1995 in the HIV/AIDS programme.

5.5.2. Organisational Structure

Figure 39 presents the organisational management structure of UNDP.

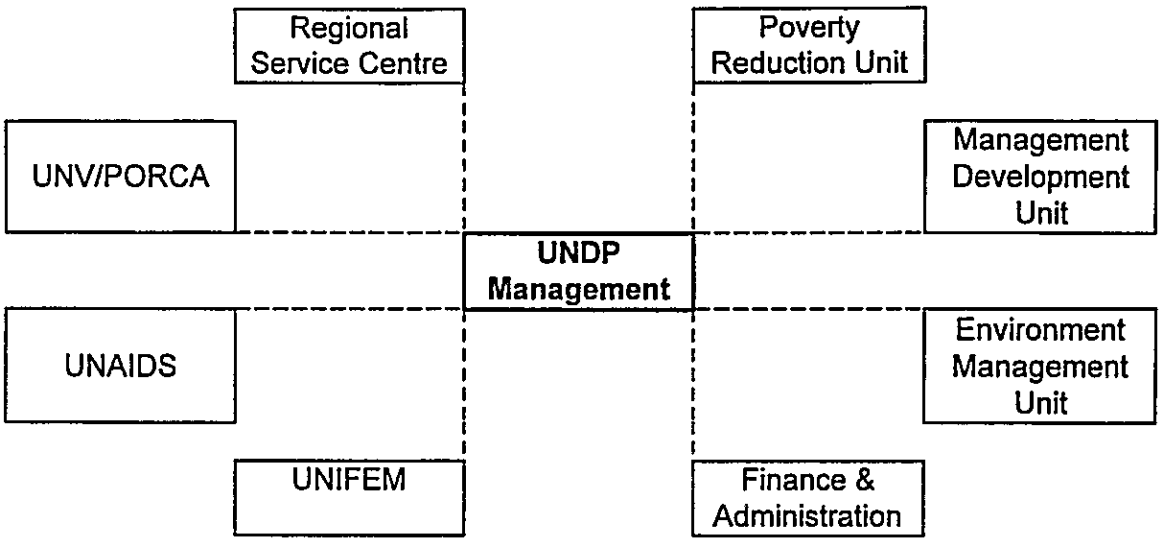

FIGURE 39 : ORGANISATIONAL MANAGEMENT STRUCTURE

5.5.3. Plan of Co-operation, Programmes Priorities in relation to the MOHCW

The poverty alleviation programme with the poverty reduction unit is the focal point in relation to health activities. UNDP is participating as co-sponsor of the UNAIDS (Thematic HIV/AIDS Group).

The UNDP supports indirectly the Poverty Alleviation Action Plan and target the vulnerable groups such as the people with disabilities through the Disability Board. The UNV programme is also supporting the social sector programme related to people with disabilities.

The UNDP is also indirectly supporting the Rural District Councils' capacity building process in the decentralisation process. The UNDP has proposed support to the

health sector in the groundwork for reforms and the decentralisation process. The Social Development Fund/PAAP which include health related issues are also supported through the UNDP.

5.5.4. Budget

UNDP has provided US $ 1 million between 1989 and 1995 for HIV/AIDS related programmes.

5.6. THE WORLD BANK (WB)

5.6.1. History of Co-operation

The collaboration of the World Bank with the MOHCW started with the Family Health Project in Zimbabwe over the period 1988-1993 and was regular reviewed by the WB members. After a review mission the follow up of the FHP was initiated. The second phase of the project is being assisted for the period 1992-1997. The sexual transmitted Infectious Prevention and Care Project 1993-1998 was another collaborative project between the WB and the MOHCW.

5.6.2. Organisation and Structure

The Headquarters of the World Bank are in Washington D.C. USA with a Resident Mission in Harare Zimbabwe. For the Health Sector there are five World Bank Staff Members of which four are in Washington D.C. and one is in Maputo, Mozambique. The World Bank Staff visits Zimbabwe about three times a year for regular programme implementation review missions.

5.6.3. The WB Policy, Priorities, Objectives and Plan of Co-operation and the Focal Point in the Relation with the MOHCW

The World Banks policy is the commitment to the cost effectiveness of services.

The World Bank has five priority objectives in its support to the health sector in Zimbabwe. The WB assist the Government in :

- fostering an economic environment that enables households to improve their health
- Rationalisation of Government's health care spending to more cost-effective primary public health programmes that do more to assist the poor
- promotion of greater diversity and competition in health financing
- Achieving more equity in services by constructing health facilities in under-serviced areas
- Assisting financially and technically programmes with a focus on Reproductive Health (MCH and FP and STI)

Under the World Banks leadership the multi-dollar funded FHP phase I (1997-1993) and the FHP phase II (1992-1997) and prevention of sexually transmitted infection (STI) (1993-1998) projects have been supporting the MOHCW including the ZNFPC. The objectives of the Family Health Project, phase II are :

- to reduce the Total Fertility Rate (TFR)
- to increase the financial sustainability of FP programmes
- to reduce the Infant Mortality Rate (IMR)
- to reduce the Maternal Mortality Rate (MMR)
- to improve the health education in the community and build capacity in the nutrition unit and strengthen nutrition activities

The plan of co-operation with the MOHCW for the current year of 1997 is the further implementation of the FHP phase II and the STI project. The preparations of the future support programmes are being discussed. The future support within the next medium and long-term plans will continue in the broad sector-wide support related to the Health Investment Project (HIP) and the social sectors.

5.6.4. Total Budget

The WB own contribution to the FHP, phase II is amounting to US $ 40 million for the duration of the project which is an International Bank for Reconstruction and Development (IBRD) loan. The WB is providing further support of US$ 65 million for the STI project which aims to strengthen STI prevention and care, this is under the form of an IDA Credit. The Health Investment Project is still under preparation and a budget has not yet been estimated but will be an IDA Credit, as illustrated in Table 31.

TABLE 31 : TOTAL BUDGET OF THE WB SUPPORT

Project	Budget in US$	Source
FHP, Phase II	40 million	IBRD
STI-Project	65 million	IDA Credit
Health Investment Project	?	IDA Credit

6. BILATERAL AND MULTILATERAL CO-OPERATION

6.1. THE SWEDISH INTERNATIONAL DEVELOPMENT AUTHORITY (SIDA)

6.1.1. History of Co-operation and Organisation

The co-operation started at Independence. It is a sector support-based agreement between the Government of Sweden and the Government of Zimbabwe. The agreement is every three years renewed on the basis of requests of the Government of Zimbabwe to Sweden. The presentation of the plan of co-operation for the components and sub-programmes are then being discussed and negotiated between both parties. After this process a financial agreement is signed on the basis of the reviews and the plan of co-operation. Annual consultations are held in which the MOHCW reports about the progress made and the plans and budgets for the following years are presented. Every quarter a quarterly disbursement meeting is held with the MOF.

6.1.2. Policy, Priorities, and Plans of Co-operation for SIDA

The development goals that direct the Swedish assistance is based upon the GOZ development plans but focused on the disadvantaged groups such as the people with disabilities and the communal farm workers.

The goals are responded to in a multi-sectoral approach. The programmes assisted by SIDA during the plan of co-operation 1993-1996 are :

- Nutrition and Child Supplementary Feeding Programme
- Farm Health Workers
- Community Based Rehabilitation
- National Aids Programme (NACP), STI
- Water and Sanitation
- Blair Research Institute
- Planning and Evaluation

All the resources in support to the MOHCW are directed through the MOHCW.

A 1997-1999 plan of co-operation will be the last agreement between the Swedish Government and the Government of Zimbabwe as Sweden is phasing out its health sector support. A possible multi-sectoral support will be given to the people with disabilities with focus on children with disabilities.

6.1.3. Budget

Funds are canalised through the MOF. Annual follow up and quarterly meetings are organised. Evaluations and regular review determine the next financial and technical assistance programme. The budget for the plan of co-operation of 1993-1996 is summarised in Table 32.

TABLE 32 : SIDA PLAN OF CO-OPERATION PROJECT SUPPORT 1993-1996

Project	Amount in Million SwK
Expanded Programme on Immunisation	18.0
Health Water and Sanitation Programme	12.0
Community Based Rehabilitation	7.5
Farm Health Workers	4.5
AIDS Control	15.0
Family Health Project, phase II	24.0
• Nutrition	(13.0)
• Manpower Development	(1.0)
• MCH	(7.0)
• Planning and Evaluation	(2.0)
• AIDS - Programme contributions to NGO's	(1.0)
TOTAL	81.0

6.2. DANISH INTERNATIONAL DEVELOPMENT AGENCY (DANIDA)

6.2.1. History of Co-operation and Organisation

The development co-operation in the health sector dates back to the beginning of the bilateral co-operation (1984). For the past ten years, a major project has been the support to the Zimbabwe Essential Drug Programme (ZEDAP). From 1993-1995 support was also given to the Governments Family Health Project. Since 1993 further support has been provided to the National AIDS Co-ordination Programme with the building of laboratory services including the training and capacity building of technologists, blood bank and the health information services.

In accordance with the overall strategy for Danish development assistance, the focus has been diverted to the development of comprehensive sector support programmes, assisting the Government, especially the MOHCW Health Reform Agenda. An agreement for the first three years and two month phase of the DHSPS Programme was signed on the 9 December 1996. Funding under this phase will amount approximately to 220 million Zimbabwe Dollars equivalent in today's currency rates.

6.2.2. Organisation and Structure

The organisation and structure of the Royal Danish Embassy including DANIDA is as follows :

The Ambassador is heading the Mission with the Consul as the Deputy Head of the Mission. There are further two Counsellors for the Development Areas and one Counsellor for the Accounting. The Attaché and the Project Officer with administrative staff and secretary are completing the team.

The Ambassador is also accredited in Angola and Botswana but in these countries there are no bilateral development co-operation agreements. The Embassy is also implementing a limited number of regional development projects such as Women and Law in Southern Africa, Peacekeeping training at the Zimbabwe Staff College.

6.2.3. Policy, Priorities and Plan of Co-operation for DANIDA

The overall Danish strategy for development co-operation is the Health for All Strategy towards the year 2000 and is also the guideline for the country strategy in the Danish-Zimbabwean bilateral development co-operation.

The main objectives is to ensure appropriate health services to the Zimbabwean population in particular the most vulnerable groups including the women and children.

The Danish Health Sector Programme Support (DHSPS), consists of eight supporting priority areas :

- support to district health services amounting to 45% of the total amount (54 15 209 Danish Krone - DKK)
- support for provincial health providers
- support for central MOHCW policy and planning department
- support for the development of an overall gender strategy for the health sector
- support to NACP's AIDS activities particularly Home Based Care at district level
- support to ZEDAP which will be phased out during the programme period
- support to the health laboratories including quality assurance programme which will be phased out during the programme period
- support to the Health Information Services (NHIS)

At the Embassy the Consul, Deputy Head of Mission is responsible for health sector activities. The day to day management is in the hands of the individual components. Overall co-ordination is done by the Strategic Development Unit (SDU), MOHCW which is supported by the Danish Advisor. Expatriate Advisors are furthermore provided to ZEDAP (2), Laboratories (1) and NHIS (1).

The implementation is supervised through quarterly meetings in the Review and Planning Group, which is chaired by the Permanent Secretary, MOHCW. The Review and Planning Group consists further of representatives from the individual components as well as the Embassy.

The Danish Health Sector Programme Support provides the framework for an envisaged medium and long term support for the health sector (10-15 years).

6.2.4. Budget

The magnitude of the financial support is expected to be maintained around approximately 50-54 million Zimbabwe Dollars per annum. In accordance with the implementation of the GOZ decentralisation reforms, it is envisaged that the programme gradually will put more emphasis on budget support, primarily to district health services provision. These services are foreseen to become gradually the competence of the Rural District Councils. The summary of the budget is provided in Table 33.

In addition to component 1-7 there is a non-allocated budget which is estimated to cover special activities in order to facilitate the implementation of priority areas within the core packages of health care, gender activities and IEC for the communities about the Health Sector reform. The activities to be funded by the centrally managed district support will be identified by the Strategic Development Unit (SDU) and appraised by the planned annual supervisory reviews. They are further subject to approval by annual consultation between the GOZ and the Government of Denmark.

TABLE 33 : BUDGET FOR 1996-99

Components of the Programme	Budget for 1996-1999 in Danish Krone (DKK)
Support to district health services	54 815 209
Support to provincial health services	8 334 411
Support to central MOHCW including the Strategic Development Unit	8 256 416
Development of a Gender Strategy for HSPS/MOHCW and support to HIV/AIDS Activities	9 000 000
Support to and integration of ZEDAP	7 605 000
Support to and strengthening of decentralised laboratory facilities	23 800 610
Support to the health information system	2 985 220
Non allocated budget	7 000 000
Sub-Total	121 628 866
Budget Reserve	8 000 000
TOTAL	129 628 866

Source : DANIDA, Ministry of Foreign Affairs : Sector Programme Support Document Phase I, 1996-1999. (DDK 1 = 1.67 Zimbabwe Dollars, 1996)

6.3. THE NORWEGIAN AGENCY FOR DEVELOPMENT CO-OPERATION (NORAD)

6.3.1. History of Co-operation and Organisation

NORAD supported the Health Sector since the mid-eighties. Their support went mostly to the Family Health Project.

NORAD has no organisation in Zimbabwe. NORAD is incorporated in the Royal Norwegian Embassy and the Ambassador is the NORAD Resident Representative.

NORAD supports SADC through several projects in the SADC-member countries of which Zimbabwe is a member. The funds are channelled through the host Governments.

6.3.2. Policy, Priority, Plan of co-operation for NORAD

The policy of NORAD is based upon the primary health care strategy and its implementation in Zimbabwe. The programmes being supported by NORAD are :

- the Family Health Project
- the Malaria Control Programme
- support to the Nutrition Policy
- the Child Supplementary Feeding Programme

These programmes are currently budgeted for. In consultation with the MOHCW, NORAD will be developing its future inputs in relation to the implementation of the Strategic Health Plan.

6.3.3. Budget

The funds are sent to the MOF through the National Development Fund. The MOHCW divides the funds according to the GOZ procedures. The funds to the Family Health Project are sent through the World Bank to the National Development Fund.

NORAD expended under a NORAD Grant the amount of Norwegian Krone 19 million in 1995. This was divided for the projects related to :

- Family Planning IEC
- Clinical Based FP Services
- Voluntary Surgical Contraception
- Youth Advisory Services
- Community Based Distributors (CBD) of Contraceptives
- Construction of Rural Health Facilities

- Training
- Supplies and materials for Safe Motherhood and Midwifery
- The Family Health Project

In 1994 the support to the health sector was amounting to NOK 53.4. million. The Norwegian contribution amounts to about 15.2 million Zimbabwe Dollars per Year.

6.4. OVERSEAS DEVELOPMENT ADMINISTRATION (ODA - UK)

6.4.1. History of Co-operation and Organisation

ODA has been supportive to the MOHCW since Independence.

A Health and Population Field Manager is the focal point of contact in ODA/Zimbabwe, concerning health related issues. The Health and Population Manager in Zimbabwe reports to the Regional Advisor in the British Development Division in Central Africa (BDDCA).

6.4.2. Organisational Chart

The organisational structure is provided in Figure 40.

6.4.3. Policy, Priorities, Plan of Co-operation for ODA

ODA has four main themes and their policy of support is directed to :

- Emergencies
- Communicable Diseases (HIV, Malaria, TB)
- MCH including Reproductive Health
- Health Sector Reform

The plans of co-operation are not necessarily on a year to year basis. If a suitable project is being submitted, ODA assesses the proposal. If it is in line with the above policy guidelines and priorities than ODA might support the programme. In this way ODA is considering the support to the Medical Equipment Management, Health Sector Reform Programme, Malaria Control Programme. The last two programmes are not very clear yet.

6.4.4. Current ODA Support to the Zimbabwe Health Sector

6.4.4.1. Sexual Health Project

The sexual Health Project forms part of the STI Control Programme for Zimbabwe. The project started in 1994/95 and runs over five FY's. It forms part of the Government strategy to control HIV. The key elements and objectives of the project are :

- to establish a STI Control Programme Office
- to assist in the policy formulation and implementation
- to promote operational research
- to equip Harare Genito-Urinary Centre

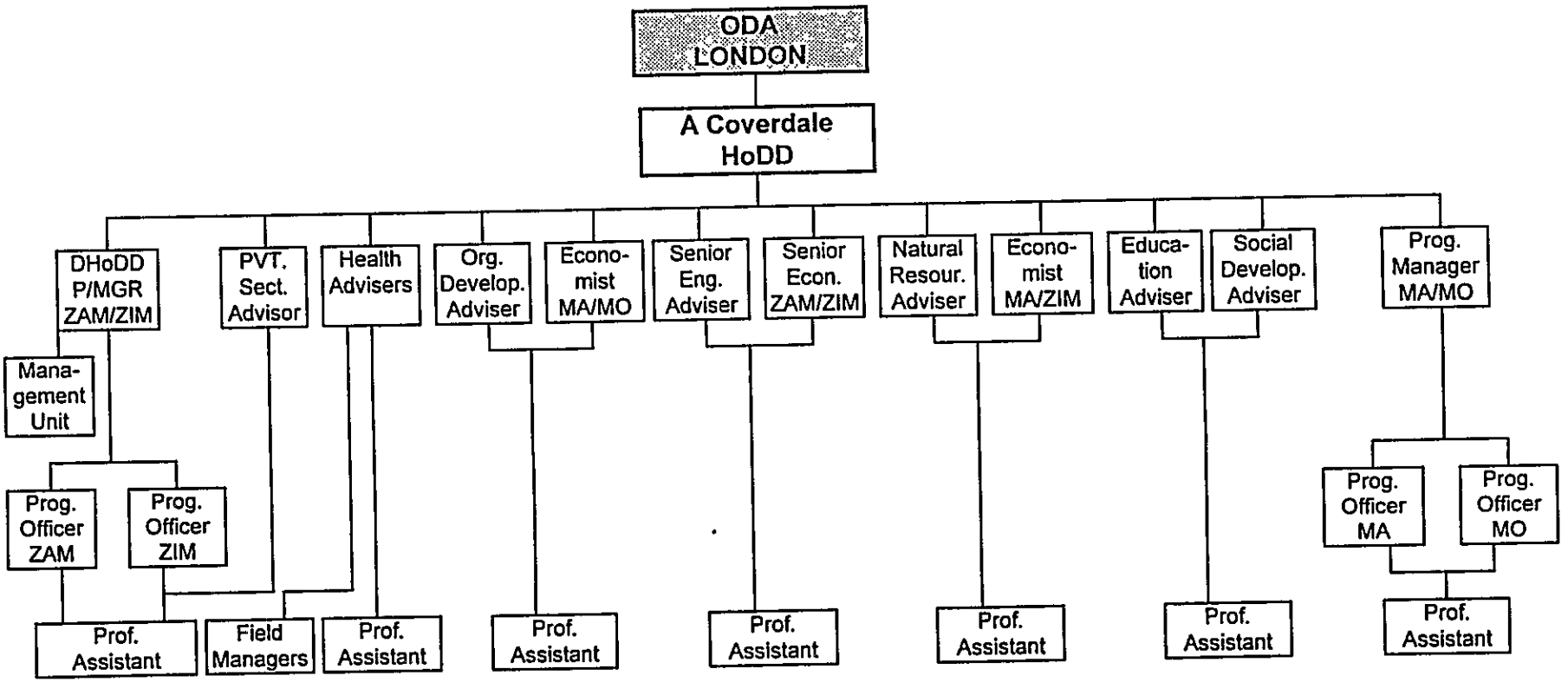

FIGURE 40 : ORGANISATIONAL STRUCTURE OF THE BRITISH DEVELOPMENT DIVISION IN CENTRAL AFRICA (BDDCA)

- to provide training to nurses, doctors, CBD and traditional healers in order to improve the detection and treatment
- to provide vehicles and equipment for the provinces
- to provide logistics support, to build capacity and to provide capital costs for the procurement of condoms

Resources : £ 9 million

6.4.4.2. Support to Health Policy Development and Planning Department of the MOHCW

This project will assist in the establishment of an upgraded and strategically focused Health Policy Development and Planning Department in the MOHCW Head Office. This Department will then in turn support the ongoing and accelerating process of the Health Sector Reform. The project will assist the Top Management Team to improve the quality of decision making by providing the Ministry with the analytical capacity for strategic development and general management of health services. The project is supporting the recruitment of additional key personnel for the department and essential office equipment. The project is running over the period October 1996 - September 1999. The key elements and objective for this project are :

- to establish a new Health Policy Development and Planning Department in the MOHCW
- to financially assist in the recruitment of the Head of the Department and two Unit Heads
- to assist in the recruitment of technical assistance for the period of two years
- to recruit support staff
- to supply essential office equipment

Resources : £ 750 000

6.4.4.3. Everyone's Child : An African Film and Education Programme

The project supported the production of a film and training programme addressing the problems encountered by orphaned children in Africa. The purpose of the project is to empower individuals, families, communities and authorities to care more effectively for an increasing number of orphaned children. The project runs over two FYs, which started in 1995/96.

The key elements and objectives of the projects are formulated as follows :

- to research and identify the knowledge, attitudes, feelings and practices concerning orphans
- based on the research, to develop the script of the feature film
- to produce and pre-test the film

- to develop a training programme based on the film
- to assess and evaluate the impact

Different donors are funding the different phases such as Plan International, Anglo-American Co-operation, Oxfam USA, SIDA and ODA. ODA funds the production, the pre-testing phase and the impact evaluation. Other donors are supporting the release of the film in Kenya and Uganda.

Resources : £ 242 660

6.4.4.4. Community Based Malaria Control Project

A community based project was undertaken in Binga District, through funding from the High Commissioner's Small Project Fund. It involves schoolchildren, teachers and local health authorities in all aspects of malaria control and prevention. The emphasis was the environmental control by the communities and schoolchildren, health education and larviciding with environmental control by teachers and environmental health workers. The pilot activity was extended in the Zambezi Valley, where the incidence of malaria is high. The project is run by SCF in conjunction with two District Medical Offices. A consultant assist with the co-ordination of the project. The key elements and objectives of the project are :

- to develop a geographical information system to locate and plot breeding sites in a district
- to undertake an impact study of the project malaria incidence
- to initiate a surveillance system to identify accurately malaria cases and the place of origin
- to undertake malaria surveys
- to undertake social studies to identify changes in risk behaviour

Resources : £ 80 000

6.4.4.5. Social Marketing of Condoms Project

This project is a joint venture between ODA and USAID. The goal is to increase condom use among people in lower and middle socio-economic groups in order to reduce the spread of HIV/AIDS and STI's. The project is supporting the development of a private market system for a condom that is affordable by those people mentioned. The project is of five years duration, starting 1996/97 until 2000/2001. The key elements and objectives are as follows :

- to provide condoms, including packaging and testing
- to staff the offices (USAID)
- to develop promotional activities, including theatre, TV, radio, bill-boards

Resources : £ 2 000 000

6.4.5. Recently Completed Project with ODA Support

- Health Management Strengthening Project

The ODA undertook an external evaluation of the Completed Project of Health Management Strengthening. The review of the project will feed later in new project developments. The period covered was December 1991-1996.

Resources : £ 2 337 000

6.4.6. Projects Under Consideration

6.4.6.1. The Management Of Medical Equipment

ODA is exploring with the GOZ a package to address the management of medical equipment. The immediate objective would be to ensure the cost effective and efficient management of Medical Equipment. The project design envisages technical assistance (estimated at £ 0.7 million to 1.0 million) for :

- the strengthening of the Equipment Department within the MOHCW
- the establishment of an accurate inventory of all medical equipment in Government Health Facilities
- the drawing of 'tenders' and the management of procurement of equipment
- the planning of maintenance and replacement of equipment and the associated financing

Resources are estimated at £ 1 000 000 but the period of implementation is not yet announced.

6.4.6.2. Future support to the Health Sector Reform

An external evaluation of the Health Management Strengthening Project which took place in October 96 will be followed by an appraisal of a five year programme of support. Areas which may be covered in a future project are :

- Management Strengthening of Central Hospitals
- Public Health (communicable diseases)
- Decentralisation

Resources and period of implementation are not yet announced.

6.4.7. Budget

ODA does not have a specific ceiling in their budget support and Table 34 illustrates the estimates for some of the projects ODA is supporting financially.

TABLE 34 : ODA PROJECT BUDGET SUPPORT

ODA - Project Support to the Health Sector	Period	Budget
Sexual Health Project	1994-1999	£ 9 000 000
Support to Health Policy Development and Planning Department /MOHCW	1996-1999	£ 750 000
Everyone's Child : An African film and Education Programme	1995-1997	£ 242 660
Community Based Malaria Control Project	1996-1997	£ 80 000
Social Marketing of Condoms	1996-2001	£ 2 000 000

Within the Completed Central Africa Project Portfolio the projects and their budget lines are divided in Bilateral Country Grants, Sector Specific Country Commitment and Sectoral Programmes Commitment. Table 35 illustrates the binding commitment.

TABLE 35 : PROJECT SUPPORT AND OBJECTIVES ACCORDING TO BILATERAL COUNTRY GRANTS, SECTOR SPECIFIC COUNTRY COMMITMENT AND SECTORAL PROGRAMME COMMITMENT

Project	Objectives	Period	Commitment
• **Bilateral Country Grants**			
Supply of Condoms	To ensure that the supply of condoms in the country is sufficient to meet the demand To help the GOZ to develop a long term strategy for contraceptive provision	1992/98	£ 390 275
Condom Procurement Component	The Multi component of Sexual Health Project is to help GOZ to combat STI including HIV/AIDS by improving STI treatment and prevention services To increase access to condoms	1996/99	£ 4 118 000
Health Management Strengthening	To improve health status, obtain optimum use of limited health resources in terms of quality of health services in line with GOZ health priorities To create sustainability	1991/1996	£ 154 550
Health Policy and Planning Department	The establishment of an improved Health Policy development and Planning Department To assist in the process of the health sector reform	1996/99	£ 427 500
• **Sectoral Programme Commitment**			
Population based studies on HIV in Developing Countries	To improve understanding of the factors that control the transmission dynamics of HIV infection in developing countries and to assess the impact of HIV on populations, specific the influence of AIDS/HIV	1993/97	£ 183 055

Project	Objectives	Period	Commitment
• **Sector Specific Country Commitment**			
Health Management Strengthening	Second phase of the Zimbabwe Health Service Management Strengthening	1992/96	£ 2 274 210
Health and Population Field Manager	To provide increased professional capacity in the country To plan and manage the implementation of ODA assistance to the health and population sector in Zimbabwe	1993/97	£ 496 155
Sexual Health Project STI Component	To help Zimbabwe combat STI including HIV/AIDS by improving STI treatment and prevention services and by increasing access to condoms	1995/99	£ 3 839 000
Condom Supply Component	to help Zimbabwe to combat STI including HIV/AIDS by improving STI Treatment and prevention services and by increasing access to condoms	1995/99	£ 1 059 000
Emergency supply of condoms	this project will provide 66 million condoms to the GOZ in order to reduce fertility and HIV transmission	1995/97	£ 1 400 000
Financial Planning and Management	Funding for a financial and planning management advisor to be seconded to the MOHCW and assist in the planning, implementation and monitoring financial management systems	1995/97	£ 199 853
Community Based Malaria Control	Education and mobilisation of sectors of the community in various malaria control activities, in particular source reduction and laviciding	1996/97	£ 84 341
Health Policy Development and Planning	Establishment of an improved Health Policy development and planning department to assist in the process of the health sector reforms	1996/99	£ 221 000
Condom Social marketing	The project will expand the social marketing of condoms and test the feasibility of social marketing the female condom	1996/99	£ 1 587 019